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EXAMINING THE STIGMA OF MENTAL ILLNESS ACROSS THE LIFESPAN

Diane M. Lowder

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Approved by

Advisory Committee

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Chair

Accepted by

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Dean, Graduate School

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ABSTRACT

Stigma related to mental illness can deter help-seeking in those who need it and result in discrimination. Studies indicate that negative attitudes toward and social distance from the mentally ill are greater among males, and those with less education and less familiarity with mental illness. This study examines attitudes toward the mentally ill among older and young adults in order to determine whether differences exist. We proposed that older adults might have more positive attitudes toward and less social distance from people with mental illness. Participants were 70 college-age students enrolled in a Psychology 105 course and 78 older adults involved in educational programming at a Senior Center. The survey consisted of a set of demographic questions, the Community Attitudes toward the Mentally Ill (CAMI) Survey, and a modified version of the Social Distance Scale. Older adults indicated greater familiarity with mental illness, but more negative attitudes and more social distance than college-age respondents. Across age groups, women and those who were familiar with mental illness scored higher on the positive attitudes subscale and lower on the negative attitudes subscale of the CAMI. Simply having familiarity with mental illness does not mean attitudes will be more positive and that attributions made by older adults may differ from those of younger adults.

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EXAMINING THE STIGMA OF MENTAL ILLNESS ACROSS THE LIFESPAN

Some of the earliest research conducted on stigma defines it as "any aspect of an individual that is deeply discrediting and thereby allows others to discount that individual as tainted" (Goffman, 1963, p. 3). It has been noted that stigmatized people are looked upon as being of "less value" and the concept of stigma indicates a shame that points toward the person (Arboleda-Florez, 2003). Historically, cultural views of mental illness stigma have had powerful consequences for help-seeking, stereotyping, and even in the kinds of treatment facilities that are created for people with mental illness (Link et al., 1999). Active (or public) stigma, which is stigmatizing attitudes among the public, has been shown to directly affect the loss of opportunities in work environments and personal relationships. This, coupled with the social skills deficits already experienced by people with severe persistent mental illness is worsened by societal stigma. The division between "us" and "them" may result in negative consequences for those with mental illness, in that "self-esteem, social adaptation, and adherence to pharmacologic treatments are all adversely affected by social stigma" (Van Dorn, Swanson, Elbogen, & Swartz, 2005, p. 153). Research suggests that a majority of employers are less likely to hire people labeled as mentally ill, less likely to lease them apartments, and are more likely to deliberately press charges against them for violent crimes (Corrigan et al., 2000). According to Gray (2001), only 21% of people with severe mental illness are working or seeking work and of those, only 13% are actually employed. These numbers represent a lower percentage working than for any other group with impairments or long-term illnesses. Read and Baker (1996) found that nearly half of those sampled in their study had been physically or verbally harassed in public because of their mental illness. Family

members of people with mental illness also commonly report experiencing forms of stigma, in that they feel rejected or avoided by others and experience their own personal strained relationships.

Associating mental illness with violence only helps to spread these stigmatizing and discriminatory practices against those who suffer with illness. Media portrayals in film or television of people with a mental illness often include psychotic killers or violent individuals who maintain little or no basis of reality, and these portrayals often use words such as: 'crazy, psycho, or schizo' to refer to those behaviors that stray from the expected norms of society (Hinkelman & Granello, 2003). The perceived probability of violence coupled with social distance from those with a mental illness is increased due to current news and media portrayals, and has an even more negative impact on the general publics' beliefs of the mentally ill (Link et al., 1999). Social stigma is far-reaching, as it affects not only those with mental illness, but those closest to them as well. However, it must be remembered that stigmatization is a common occurrence, it is pervasive and often subtle in its effects, and is often difficult to counteract without clear strategies to do so. To better understand the processes that underlie stigmatizing attitudes and discriminatory practices, we examine attribution theory and related models of stigma.

Attribution theory

Attribution theory is a social-cognitive model that examines the perceived causes of the activities of other people (Weiner, 1986). Attribution theories attempt to describe the psychological operations that lead people to adopt situational or dispositional interpretations of other people's behavior. Chan and colleagues (2005) state that

stigmatizing attitudes toward those with disabilities can be assessed in the following terms:

a) controllability of the impairment; i.e., the extent to which the person is responsible for the condition and its remediation as opposed to environmental forces or biological disease agents; and

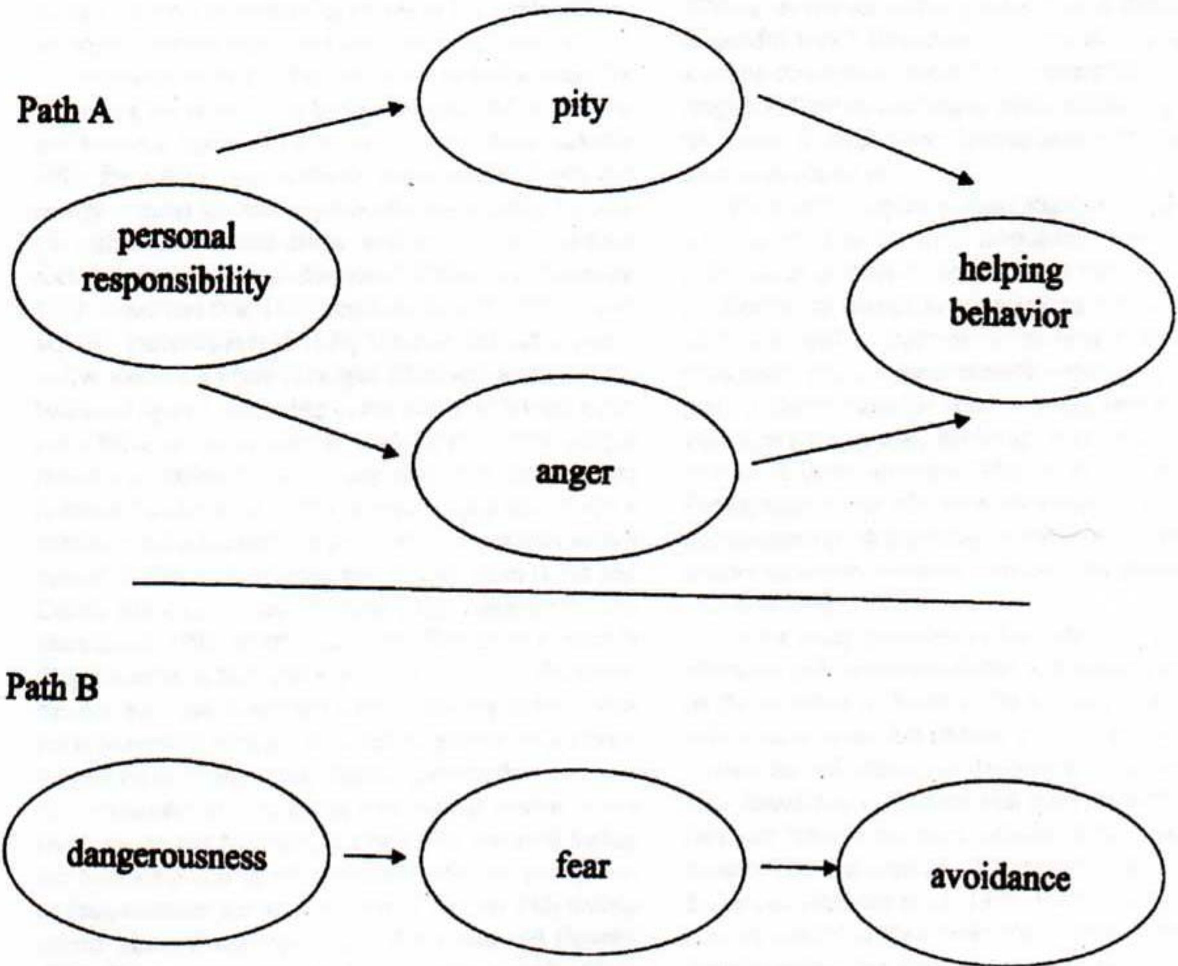
b) stability of the impairment; i.e., the extent to which a specific condition is expected to change or improve over time (p.78).

Weiner and colleagues (1988) examined the differences in controllability and stability attributions across two groups of people with disabilities: physical disorders (e.g. Alzheimer's disease, blindness, cancer, heart disease) verses mental-behavioral disorders (e.g. drug abuse, obesity, and PTSD) and found that participants saw the mental-behavioral group as more in control of their disorders, less worthy of pity, and with a worse prognosis than those with a physical disorder. Therefore, those with mental illness were seen as victims of greater stigmatizing attributions. The authors concluded that the general public discriminates among disability groups and views mental illness more negatively. Corrigan and colleagues (2000) found that discrimination among disabilities often depended on the type of attribution. For example, cocaine addiction was rated the worst according to their sample, followed by psychosis, and AIDS; people with these problems were perceived as having more control over their illnesses.

Weiner (1996) has argued that the emotional reactions of pity and anger have diverse implications for the behavioral tendencies of stigma toward mentally ill or handicapped people. Anger has been said to motivate hostility toward and the rejection of the person, whereas pity provokes prosocial behavior and consequently reduces social

rejection. Weiner supports that these emotions are caused by the degree to which individuals are believed to be personally responsible for the onset of their condition. Therefore, the more people are seen as personally responsible for their condition, the more anger and the less pity they will arouse (Weiner, 1996). The hypothetical paths of these emotional reactions (anger and pity) described by Weiner are outlined in Figure 1[1]. These ' degree of responsibility' attributions help explain the relationship between stigma and consequent discrimination, however, the idea that those with mental illness are dangerous and should be separated from others in society is yet another model that has been proposed (as shown in Figure 1). Several studies have found a connection between perceiving people with serious mental illness as dangerous and fearing them; thus producing social distance and avoidant behaviors (Corrigan et. al, 2002). Other research on the stereotypes related to attributions about personal responsibility and blame, has found that "participants who blame relatives for the onset of other relatives' mental illness are more likely to react angrily to those relatives, withhold help, avoid them socially and to support coercive mental health services (Corrigan, 2006)." According to this 'attribution-emotion model' of stigma, several studies have shown a relationship between viewing people with a mental illness as dangerous, and the associated fear, producing discriminatory behaviors or social distance from those with a mental illness (Corrigan et al., 2001). These finding have been supported by Angermeyer and Matschinger (1996) who found that a fearful response to two political assassination attempts attributed to people with schizophrenia led to an increase in social distance between the general public and those with severe mental illness.

Figure 1.



[1] The figure is from: Challenging two mental illness stigmas: Personal responsibility and dangerousness, by Corrigan, P.W. et al, 2002, *Schizophrenia Bulletin, 28*, 293- 307.

Compared with other mental illness, Schulze, Richter-Werling, Matschinger, and Angermeyer (2003) concluded that schizophrenia was associated with the most negative media coverage and the poorest public image. Stuart and Arboleda-Florez (2001) report that, of all mental illnesses, paranoid schizophrenia is the most recognized and least accepted disorder by the general public. Van Dorn and colleagues (2005) suggest that the reason for the public's negative perception of schizophrenia is that it is often associated with attributions of unpredictability and dangerousness. The authors also reported that the relationship between the diagnosis of schizophrenia and the desire for social distance from those with a mental illness has been attributed mainly to the fear of potential danger and not to the actual symptoms of a diagnosis. In reality, people who are in treatment for a mental disorder are not more likely than people without a mental illness to become violent (Steadman et al, 1998). Yet, they are nearly three times more likely to become victims of violent crime (Hiday et al 1998).

A defensive attribution considers variables such as the nature of the victim, the extent to which unpleasant consequences were already suffered by the perpetrator, and the clarity with which the behavior could be deemed as 'blameworthy' and has the possibility to effect attributions to the causes of those with a mental illness (Shaver, 1970). Shaver has hypothesized that defensive attribution will not occur unless the observer can identify with the victim, meaning both the severity of consequences and the levels of attributed personal responsibility should be influenced by the apparent similarity (either personal or situational) between the actor and observer (Sadava, Angus, & Forsyth, 1980). For example, someone with an illness is more willing to blame external factors as the cause of the illness (such as stress, environmental factors), while others

(general public) blame more stable, internal causes for the illness (such as biological/genetic predispositions). Data gathered from Sadava and colleagues' study (1980) indicated that less responsibility was assigned to the controlled 'normal' case and to the anxiety case, while more punitive responses were given in the paranoid schizophrenic and alcoholic cases. Both findings are consistent with defensive attribution theory.

Social distance data from this same study revealed a model of rejection that is consistent with the explanation that an inability to identify with the protagonist is tied to the allocation of more blame to that person. Nathan, Wylie, and Marsella (2000) suggest that environmental or situational attributions regarding the causes of another's illness are generally associated with better familial relationships and quality of life, while attributions that cite the cause of illness as being rooted in the individual or family are associated with more negative outcomes. Kahng and Mowbray (2005) found that the effects of causal attributions on a person's self-esteem vary by their perceptions of social roles as well as by one's mental health status. Therefore, when subjects identify more positive social roles associated with themselves, they are said to make causal attributions for various causes of mental illnesses in a way that protects their self-esteem.

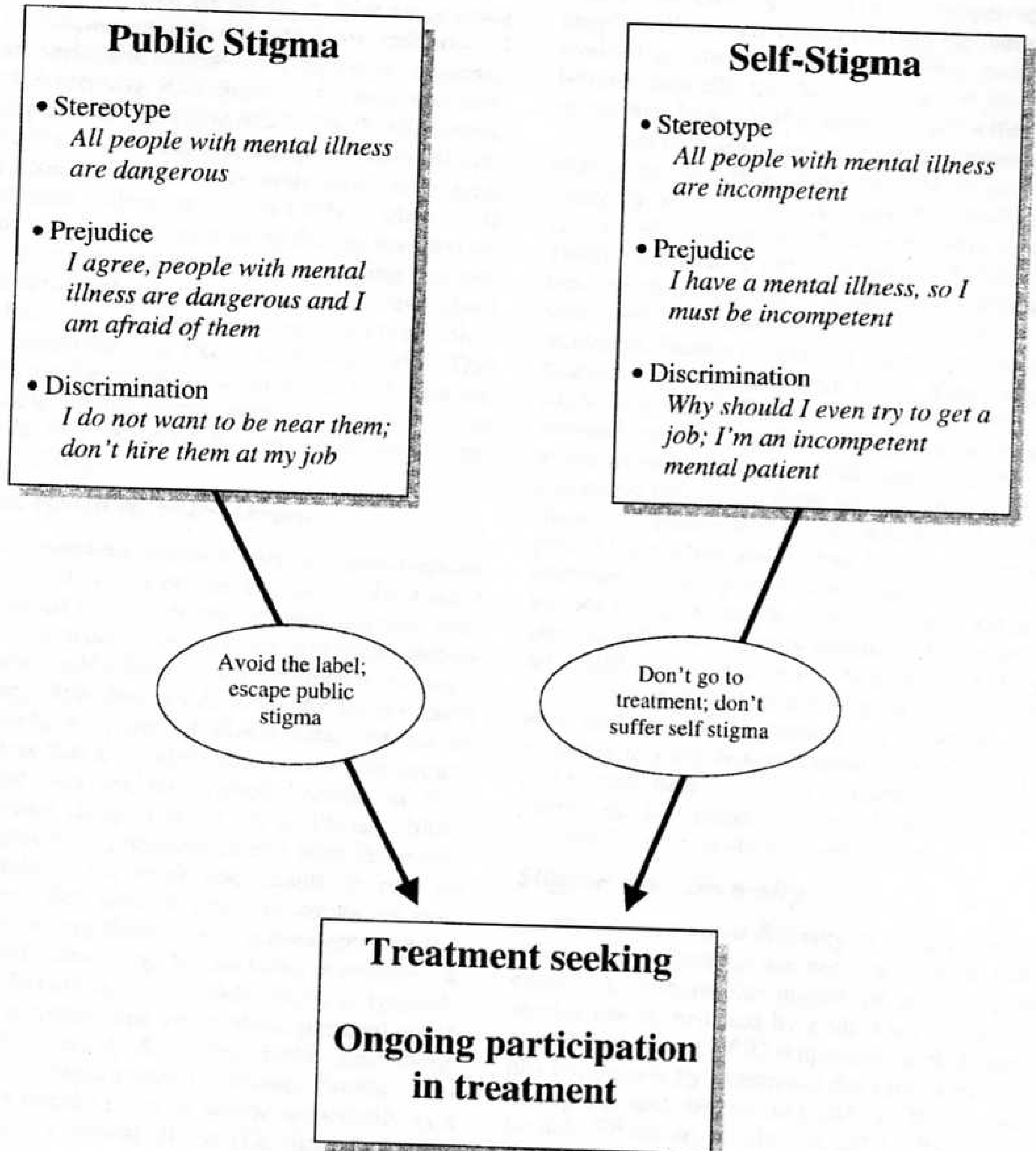
Labeling theory

Labeling theory, another social cognitive model, suggests that once a person is labeled as mentally ill, pre-existing stereotypes are activated in others, so that the public generally perceives the mentally ill person as threatening and socially undesirable (Sibicky and Dovidio, 1986). Based on these perceptions of those with mental illness, people will alter their behaviors when they prepare to interact with those with mental

illness. People who have a mental illness may then internalize others' expectations into their own self concepts, leading to a further sense of loss of self-control and continuing deviant behavior (Sibicky and Dovidio, 1986). Angermeyer and Matschinger (2003) concluded in their study, that labeling someone as having a mental illness has an influence on public attitudes towards people with schizophrenia, and negative effects visibly outweigh any positive effects of attitude change. In addition, they found that supporting a stereotype of dangerousness has a strong negative effect on the way people react to someone with schizophrenia and increases the likelihood that the person will seek social distance from the person with a mental illness. Therefore, this labeling effect implies that, regardless of the specific psychiatric diagnosis or level of disability of a person; the person labeled as 'mentally ill' will be stigmatized more severely than those with other health conditions.

Not only are those with mental illness disadvantaged socially due to stigma, they may also be less likely to seek help for their problems. Seeking psychological treatment may also be associated with stigmatization (see Figure 2)[2]. Studies suggest that seeking psychological aid may result in negative evaluations and rejection from others (Sibicky and Dovidio, 1986). Wrigley and colleagues' study (2005) suggests that person-based causal attributions (those which involve the mentally ill person and/or their family) are more likely to be linked with negative attitudes toward professional help-seeking behavior. In particular, subjects associated 'a weakness of character' with more negative attitudes toward those seeking help for both schizophrenia and depression. They also report the most frequently cited reason for not seeking professional help was embarrassment, followed by not knowing from whom to seek professional help.

Figure 2.



[2] The figure is from: How stigma interferes with mental health care, by Corrigan, P. W., 2004, *American Psychologist, 59*, 614-625.

More importantly, it is believed that many of the benefits and gains acquired by clients through the therapeutic process may be jeopardized by these stereotypes. It has been noted that even a person described as seeking counseling as opposed to treatment for mental illness is rated more negatively than a 'normal person' (Wrigley et al, 2005). Research has also shown that the fear of mentally ill people is not only related to the behavior sometimes demonstrated by affected persons, it is also related to the label itself (diagnoses) and to the consequences that flow from the illness (Arboleda-Florez, 2003).

Theoretical models of stigma

Three paradigms have been proposed to explain stigmatizing attitudes about any out-group: socio-cultural perspectives, motivational biases, and social-cognitive models. Socio-cultural perspectives claim that stigmatizing attitudes are developed by the general population to rationalize existing community injustices (Fiske, 1998). An example of this model would be when an individual says "Mentally ill people are homeless because they just don't want to work." The Motivational Bias perspective holds that people develop stigmatizing attitudes in order to meet one's basic psychological needs. For example, someone may develop an 'us-them' mentality believing that they are normal and safe from any mental illness, while others who have mental illness are sick because something is ultimately wrong with that person. Social-Cognitive theories conceptualize stigmatizing attitudes as rooted in knowledge structures, or schemas, which develop from one's own personal experiences (Corrigan, 1998). Corrigan and colleagues (2000) believe social-cognitive models are the most promising because they provide a richer theoretical basis and multiple opportunities for interventions that may ultimately be successful in

changing stigmatizing attitudes at a societal level. Corrigan (2004) considers four social-cognitive processes that can lead to the discrediting of a person with mental illness:

a) cues, such as mental illness labels, symptoms and social skills deficits
b) stereotypes, knowledge structures or beliefs of a particular social group
c) prejudiced attitudes, reflecting an evaluative or affective component, and
d) discriminatory behavior.

While it is important to note that these stigmatizing ideas or attitudes do not inherently hurt people (including those with a mental illness and their family members), the discriminatory behaviors that arise from these attitudes are, in fact, harmful.

Perceiver's attitude and perceiver's behavior

Research has shown that discriminatory attitudes about out-groups (such as those with mental illness) are related to specific behavioral reactions in the community (Fiske 1998). For example, those people who support stigmatizing attitudes are far less likely to hire or to lease property to those people with severe mental illness. One study found that approximately 75% of family members believed the pain and discrimination that resulted from stigma "decreased their children's self-esteem, hindered their ability to make friends and undermined their success in obtaining employment" (Corrigan, 1999, p. 766). The impact of stigma is not only limited to discrimination by the general public; some people with mental illness also endorse stigmatizing attitudes toward other people with psychiatric disability, which can be considered self-stigmatization. These negative attitudes and behaviors result in a diminished self-esteem among those with mental

illness; reducing the likelihood of seeking appropriate treatment, and of being successful in finding housing options, employment options, and opportunities for social relationships.

Anti-stigma strategies

Three anti-stigma strategies, reviewed by Corrigan et al. (2000), have been introduced in healthcare organizations along with other clinical services in an effort to break down the barriers to seeking treatment and ultimately, to better the quality of life of those with severe mental illness. The first strategy is education, or "a way to challenge the myths of mental illness with factual information"; protest: "making moral appeals to stop stigmatizing persons with mental illness"; and contact: "facilitating equal interactions between the public and persons with mental illness" (Corrigan et al., 2000, p. 92). Studies on reducing the effects of these stigmatizing stereotypes and discrimination against the mentally ill have yielded mixed results.

In their review, Corrigan and colleagues (2000) suggest that changing stigmatizing myths through the anti-stigma strategy of education may not generalize to broader, less stigmatizing, attitudes about mental illness, and that protest seems to produce rebound effects due to social reactance. In other words, individuals may develop more negative attitudes to mental illness as a result of implementing protest strategies to combat stigma. Van Dorn and colleagues (2005), suggest that subsequent research on the benefits of education may depend on the type of information presented and to whom the information is presented. For example, educating students on post-treatment options for those with a mental illness reduced stigma, but educating them about psychotic symptoms of those with a mental illness was associated with an increase in negative

attitudes towards mental illness. According to Reinke and colleagues (2004), research on the contact strategy has been shown to produce the best changes and suggests that members of the general public who are more familiar with those labeled as mentally ill are less likely to support any prejudicial attitudes towards the mentally ill. Further research on these anti-stigma strategies, specifically on that of the contact strategy will continue efforts to produce decreases in stigma at a societal level.

Gender and attitudes toward the mentally ill

Gender and age of the perceiver have been examined for their relationship to attitudes towards those with a severe mental illness. Women have been found to use mental health services more than men, across all age groups (Roy & Storandt, 1989). Reasons underlying this statistic has been grouped into three theoretical categories: biological, role socialization and labeling. The biological theory suggests that women are biologically less able to cope with stress and therefore need help more often than men in coping with psychopathology. The role socialization theory attributes greater psychopathology to women based on the social roles they play in society (such as spouse, mother, employee, provider, etc). Labeling theory suggests that there are no sex differences in mental illness between men and women but that women are more likely to be labeled mentally ill because of the sex differences in emotional expressiveness, help-seeking, methods of symptom presentation and by stereotyped responses of many health professionals towards women (Roy & Storandt, 1989). Beier and Ackerman (2003) suggested that women have more experience than men in the healthcare domain, partly because of the roles many women play as family care-provider in our society. This familiarity makes it easier for women to seek help from health care professionals while

men are less likely to visit physicians and to participate in preventive measures. In their study, women, on average, scored higher on each measured health domain such as reproduction, childhood early life, common illnesses, and serious illnesses. Horwitz (1977) concluded in his study that women were more likely to identify the existence of emotional problems and that this adds to the observed sex differences in mental health service utilization and other areas. Previous gender research has suggested that women all across age groups have more tolerant attitudes toward the mentally ill and help-seeking.

Recent work has used the community Attitudes toward the Mentally Ill (CAMI) to measure attitudes that are associated with stigma. Developed by Taylor and Dear (1981), The CAMI (Community Attitudes Toward the Mentally Ill) is comprised of two attitude scales, the Opinions about Mental Illness (OMI) and Community Mental Health Ideology (CMHI). The measure yields scores on subscales that comprise two separate factors: positive attitudes (Benevolence and Community Mental Health Ideology subscales) and negative attitudes (Social Restrictiveness and Authoritarianism subscales). Leong and Zachar (1999) found that female college students had less restrictive and more benevolent attitudes towards people with a mental illness, and that the female students had more positive attitudes toward seeking psychological services than their male counterparts. In past studies, men have often scored higher on measures of authoritarianism and social restrictiveness than women on the Community Attitudes toward Mental Illness scale (CAMI) indicating an overall more negative attitude toward those with mental illness (Hinkelman & Granello, 2003).

Age and attitudes toward mental illness

This research proposes that older people of both genders are more likely to be more open-minded than younger people when considering attitudes toward and social contact with the mentally ill due to experience or contact. According to Mowbray and colleagues (2006), the percentage of the population with a psychiatric diagnosis is rising, especially among younger adults, and among these, a rise in those pursuing a college education has also been on the rise in recent decades. Prevalence rates of mental illness for 2005 are the highest for youth in the age category of 15-21 years old, corresponding to the traditional college years. Furthermore, it is reported that approximately 12-18 % of students on college campuses have a diagnosable mental illness, and these high rates represent an increase in the past 50 years of the prevalence of psychiatric and substance use disorders (Mowbray et al., 2006). The issues surrounding the increases in numbers of college students with a mental illness affect not only those students, but also faculty, advisors, family and friends of those pursuing a higher education.

Research suggests that when providing contact to the general public concerning people with a mental illness, positive attitudes are strongest when the contact was provided in the context of general undergraduate training (Corrigan, 1999). A study conducted by Heights and colleagues (1998), involved exposing adolescents to a brief instructional unit on mental health. Following the exposure, the adolescents were more willing to seek professional help for emotional problems compared to those in a control group. Research indicates that the relationship between factual knowledge about mental illness and willingness to seek help may be mediated by individual attitudes toward mental illness (Sheffield, Fiorenza, & Sofronoff, 2004). Heights and colleagues (1998)

also found that female high school students regarded mental health issues as more harmful than did sampled males. Women were more likely to recommend seeking professional help as a solution to the issues, suggesting that adolescent Women have more positive attitudes towards people with mental illness than do adolescent men.

While research on adolescents and young adults indicates that their attitudes toward the mentally ill and toward mental health therapy are somewhat positive, research on older adults is equivocal. Attention has been traditionally focused on the physical health, as opposed to their mental health, of people over 65. Aging clearly affects every dimension of health care, and it has been suggested that the mental health of this age group has been neglected. Older adult stigmatization combines two sets of factors: the presence of a mental disorder and the status of the elderly in our society, the lower the social status, the higher the stigma in return (De Mendonca Lima et al., 2003). According to Graham and colleagues (2003), mental illnesses in older adults are widespread, place tremendous burdens on caregivers and health care systems, and represent significant financial costs. These costs will increase exponentially as lifespan continues to lengthen. In this respect, stigma continues to remain a major barrier to access to adequate healthcare for older people with mental disorders. McGuire (1989) suggests that lower rates of service utilization, within this age group, can be due to several factors such as a lack of faith in the therapeutic process, preference among therapists for younger clients, and most importantly, financial factors hindering older adults to seek appropriate help.

Some of the more common disorders that are associated with more stigmatization in the older population include: depression, dementia, delirium, psychosis,

and anxiety and substance abuse disorders. Participants in a study by De Mendonca Lima and colleagues (2003) measured attitudes toward those with various types of illnesses and reported that stigma toward people with Alzheimer's disease was a less than that for people with psychosis. This reported difference in attitudes toward someone with Alzheimer's versus someone with a mental illness may be attributed to the stability/controllability of the symptoms of the disorder. Allen and colleagues (1998), notes a statistically significant negative correlation between age and self-reported depressive symptoms; older people showed much lower rates of self-reported symptoms, suggesting that older people are less likely to perceive major depression as a psychological or emotional problem in later life. In a national survey of Australians, Davidson and Connery (2003) found that few adults between 18 and 74 could correctly identify symptoms of depression, and less than half of those sampled thought it would be helpful to see a doctor for treatment of symptoms. Yet, depression and senile dementia may be the most prevalent mental illnesses among older adults. McGuire (1989) estimates that, "16% of the elderly who reside in nursing homes have a primary diagnosis of a mental disorder or senility, and between 50% and 75% manifest significant symptoms of emotional and behavioral problems" (p. 819).

Findings of other studies seem to confirm that older adults are less likely to acknowledge depressive symptoms and are less likely to seek professional help than younger adults. Rogers and Delewski (2004) found that older adult participants perceived fewer negative effects from their illness than did their clinicians and viewed the consequences of their mental illnesses as far less disabling than did their clinicians. In a recent study of attitudes toward treatment, younger subjects noted psychotherapy as the

preferred treatment choice, but few of the older participants acknowledged depressive symptoms as serious enough to warrant treatment (Davidson and Connery 2003). They further hypothesized that if older adults were given improved coverage in healthcare, some of the differences in service use compared to younger populations would decrease.

Graham and colleagues (2003) believe that in the case of older people with mental disorders, the causes of stigmatization include but are not limited to: "ignorance and misconceptions of facts regarding the nature of old age, mental disorders and treatment; fear of injury/the unknown; the drive for social conformity/security, and self-stigma by those affected" (p. 673). The stigma against older people leads to the development of negative attitudes and discriminatory acts, such as: "prejudice, ageism, mistaken beliefs about individuals' responsibility for their mental disorder, the creation of misleading stereotypes of older people and the mentally ill, damaging self-beliefs, negative professional attitudes towards older people, and negative attitudes towards services offered" (Graham et al., 2003, p. 673).

Educational level and attitudes

Stigma against people with a mental illness exists not only across gender and age, but extends through education as well. Attitudinal research has generally found that older participants of lower educational level and lower social class have the most negative attitudes towards those with mental illness, and that contact with those with a mental illness can lead to more favorable attitudes (Gray 2001). Hayward and Bright (1997) also support this finding, suggesting that those who are older, less educated and who belong to the lower occupational/social classes tend to hold less favorable opinions toward the mentally ill. Wolf and colleagues (1996) suggest that a link between negative attitudes

and lower social class or educational level may actually be due to a lack of knowledge about mental illness across those groups. He further proposes a positive relationship between knowledge and tolerance. Research findings using the CAMI (Community Attitudes toward the Mentally Ill) showed that all groups with negative attitudes towards those with a mental illness demonstrated a lack of knowledge related to at least one variable measured in the study (Wolf et al., 1996).

Familiarity, experience and social distance effects

The idea that social contact between majority and minority group members would lead to more favorable outcomes is known as the 'contact hypothesis' originally proposed by Allport in 1954. Specifically, when the contact situation allowed participants equal status and a mutual goal, group members reported more favorable attitudes toward the measured out-group. Contact between groups is expected to produce more positive attitudes not only toward the specific out-group members themselves, but towards the whole group in general. Social contact with members of a stigmatized group has been said to remove negative stereotypes and decrease prejudice against minority groups. Desforges and Colleagues' study (1991) found that after students who were described as being prejudiced participated in a cooperative task with someone described as being recently released from a hospital, students were found to have more positive attitudes about the mentally ill. These attitudes were then shown to generalize to more positive attitudes toward those with mental illness in general. Polyakova and Pacquiao (2006), suggest that a change in the social context of psychological and mental illness and positive personal experiences with mental health services can bring substantial changes in people's views about mental health services and mental illness.

A change in the social context of mental illness can result in changes in the meaning of, expression of and attitudes toward mental illness and positive personal experiences may allow individuals to readily seek out professional help if needed in the future. The results of three of Wolf's studies (1996 a, b, c) indicate that *contact* with people with mental illness is the primary influence on people's attitudes, and that objective information about mental illness is less important in attitudes and behavior change. Increased social contact with people with a mental illness, in these studies, not only led to more increased knowledge of mental healthcare (and illness), but also allowed subjects to become more familiar and comfortable in these settings, leading subjects to become less socially distant in future situations involving those with mental illness.

Familiarity with a person with mental illness may influence the development of more positive attitudes toward people with psychiatric disabilities. Corrigan and colleagues (2001) examined the relationship between familiarity with and social distance from people with severe mental illness, using the Social Distance Scale (Bogardus, 1925) and concluded that increasing public familiarity through a series of vignettes of people with severe mental illness will, in fact, decrease stigma. The Social Distance Scale contains six items rated on a scale of 0 to 3, where 3 indicates a definite unwillingness to associate with, and higher scores represent a greater desire to distance oneself from people with a mental illness. This scale has been shown to have good reliability and validity and has been modified and used throughout stigma research as a substitute for behavioral indices of discrimination against people with mental illness (Corrigan et al., 2001).

Corrigan and colleagues (2001) believe that the effects of familiarity and social distance reveal the impact of stigma; familiarity influences stigma which ultimately influences social distance. It is said that those who endorse stigmatizing attitudes are more likely to socially distance themselves from those with mental illnesses and this is evident in discriminatory practices, such as: prejudice, ageism, the creation of misleading stereotypes of those with mental illness, and negative attitudes towards professionals and services offered. The term familiarity in this context is known as knowledge of and experience with mental illness. Degree of familiarity ranges from watching a television portrayal of someone with a mental illness; having a friend, co-worker, or family member with a mental illness, to even having a mental illness oneself. Corrigan and colleagues' study (2001), suggests that members of the general public who are somewhat familiar with severe mental illness are less likely to believe that mentally ill people are dangerous, respond with less fear, and in turn, have lower scores on measures of social distance to those with a mental illness. Van Dorn (2005) suggests that the "positive impact of increased contact in reducing stigma is seen regardless of age, education, and sex" (p. 154). Social scientists have commonly found that broader and more diverse experiences lead to greater acceptance of and tolerance for, others who are different.

In their Israeli sample, Schwartz and Armony-Sivan (2001), found that prior personal contact (some contact verses no contact) with those with mental retardation or mental illness was not related to attitudes. However, this lack of a relationship may be influenced by an array of factors. Markas (1993) divides these factors into quantitative factors, such as those of the number of individuals known, length of contact with the individual, frequency of contact and qualitative factors such as those of the status of those

interacting, degree of intimacy between those interacting, and pleasantness of contact between the two. According to Schwartz and Armony-Sivan (2001), it is the quality of contact and the contact situations themselves that are said to be more important than whether the person has simply had contact or no contact with a person with mental illness.

Although the literature reviewed here provides some answers about the potential influences on stigmatizing attitudes, several questions remain unanswered. This project aims to combine strategies used by other researchers in order to gain a clearer understanding of attitudes toward mental illness among college-aged and older adults. Given that education level appears to be a strong influence on attitudes toward mental illness, this project attempts to hold education-level constant, using only those participants with some college experience. If education-level is controlled for, do age differences in attitudes toward the mentally ill exist? Given that social contact and personal experience with those with a mental illness is said to decrease social distance and increase positive attitudes toward mental illness, will older adults with greater opportunities to encounter people with mental illness show greater acceptance of and decreased social distance from those with a mental illness? Finally, previous research has indicated that women have generally more positive attitudes toward mental illness over those of males. Will these differences remain regardless of participant age?

The proposed research

The specific aim of this project is to assess typical college-age student perceptions and attitudes toward mental illness as compared to those views and attitudes of older adults (ages 50 and older) and to see if one's life experiences or knowledge of

mental illness is associated with attitudes toward, and social distance from, people with a mental illness. Other demographic variables such as, highest education level completed, prior work experience with the mentally ill, and gender were examined for their relative contributions to attitudes toward the mentally ill as well. Previous research has suggested that it is the number of people known with a mental illness, the proximity of the relationship and the length of time known that affects the familiarity component of whether or not someone will be more socially distant from those with a mental illness. Therefore, this study includes in the demographics questionnaire several questions concerning these factors (Markas, 1993).

Hypothesis 1: Participants classified as being familiar with mental illness, are expected to exhibit significantly higher positive attitude scores, and lower negative attitude scores on the Community Attitudes toward the Mentally Ill (CAMI), exhibiting more tolerant attitudes towards those with mental illness.

Hypothesis 2: Participants who indicate familiarity with mental illness are expected to show significantly less social distance from those with a mental illness than those without familiarity with mental illness.

Hypothesis 3: The older population sample is expected to show significantly higher positive attitude scores and lower negative attitude scores on the CAMI, indicating more tolerant attitudes toward the mentally ill. The older sample will also indicate significantly less social distance because of increased opportunities for contact with mental illness. The college-age population sample, due to decreased opportunities for contact with those with mental illness is expected to show greater social distance and less tolerant attitudes towards mental illness than the older sample.

Hypothesis 4: Women across both age groups will score significantly higher than men on the positive attitude subscales (benevolence and community mental health ideology) of the CAMI and lower on the negative attitude subscales (social restrictiveness and authoritarianism), therefore predicting more positive (tolerant) attitudes towards the mentally ill, while exhibiting less social distance from them on the Bogardus Social Distance Scale.

Results may inform future research on mental illness stigma and attitudes. Findings could also provide a better understanding of how to approach anti-stigma campaigns (which strategies will work better for specific age groups), and help-seeking behaviors across the lifespan of the aging population.

METHOD

Participants

Seventy University of North Carolina at Wilmington, young adult, general psychology students (M= 19.27, SD = 1.48, range18-29) and 78 (M = 66.76, SD = 9.96, range 50-84) older adults contacted through the New Hanover County Department of Aging, Senior Center (See Table 1).

An independent samples t-test was also conducted on age and education in order to determine whether significant differences existed between college-age participants and older adult participants' level of education. A statistically significant relation was found between these variables of education. College-aged participants had significantly higher levels of education than those of sampled older adults ($t(148) = 3.74$, $p < .05$). Since the variables of education were meant to be held constant, education is held as a co-variate of attitudes toward the mentally ill. Table 2 depicts the means and standard deviations of all variables used in this study.

Table 1. Age of Participants by Gender

	Old	*Young*	*Totals*
Men	13	29	42
Women	65	41	106
Total	78	70	148

Table 2. Means and Standard Deviations for All Variables.

	Variables	Means	S.D.
College-Age			
	Ed. Level	14.23	1.02
	Pos. Attitudes	7.52	0.772
	Neg. Attitudes	4.27	0.732
	Age	19.27	1.48
Older Adults			
	Ed. Level	11.65	5.67
	Pos. Attitudes	7.35	1.1
	Neg. Attitudes	4.63	0.955
	Age	66.75	9.96
Older and Younger Adults Combined			
	Familiar	7.61	1.03
	Unfamiliar	7.26	0.865
	Women Pos. Attitudes	7.589	0.921
	Men. Pos. Attitudes	7.035	0.96
	Women Neg. Attitudes	4.37	0.871
	Men Neg. Attitudes	4.66	0.854

All procedures were approved by the UNCW Institutional Review Board on August 16, 2006. Due to the anonymity of these surveys, signed informed consent was not required. However, all subjects were informed that participation was entirely voluntary and that they may quit at any time while completing the surveys. Surveys had only a subject number written at the top of the first page. Participants received a card that listed the contact information for the student and faculty investigators should they have wished to receive a summary of the results or if they were to have any questions concerning the research.

Materials

The survey was comprised of three sections: a demographic information portion, the Community Attitudes toward the Mentally Ill (described below) and a modified Social Distance Scale. A brief background information survey was designed to gain information about each participant's gender; ages, highest levels of education completed, and whether he/she had any familiarity with the mentally ill (see Appendix A).

The second part of the survey consisted of the Community Attitudes toward the Mentally Ill (CAMI) developed by Taylor and Dear (1981). The CAMI was developed by using the two most previously widely used scales, the Opinions about Mental Illness scale and the Community Mental Health Ideology scale (Taylor and Dear 1981). The CAMI operationally defines mental illness as, referring to people needing treatment for mental disorders but who are capable of independent living outside a hospital. Participants were asked to respond to questions regarding their beliefs about mental illness and people with mental illness. The questionnaire consists of 40 statements, each

requiring a rating of the participant's degree of agreement/disagreement on a 5-point Likert scale (1 = strongly disagree to 5 = strongly agree). The CAMI yields four attitude factor scores, each calculated by adding the ten relevant items and then dividing by ten to obtain a mean score for each of the four factors. The four attitude factors are as follows:

1. Authoritarianism: reflects a view of the mentally ill as an inferior class requiring coercive handling. It measures sentiments regarding the need to hospitalize those with mental illness, the difference between people with mental illness and normal people and the importance of custodial care.
2. Benevolence: reflects a sympathetic view of those suffering from a mental illness based on humanistic and religious principles. It addresses sentiments such as the responsibility of society to those experiencing mental illness, the need for sympathetic, kindly attitudes, and willingness to become personally involved.
3. Social Restrictiveness: reflects a view of the mentally ill as a threat to society. This addresses sentiments involving the dangerousness of people with mental illness, the need to maintain social distance and the lack of responsibility on the part of mentally ill people.
4. Community Mental Health Ideology (CMHI): reflects a view that recognizes the therapeutic value of the community and acceptance of de-institutionalized care (Taylor and Dear 1981).

For the purposes of this study, the benevolence and community mental health ideology subscales combined to form the positive attitude factors for analyses and the social restrictiveness and authoritarianism subscales combined to form the negative attitude factors. The CAMI was developed so that two subscales reflected positive

attitudes, while the other two reflected negative attitudes towards those with mental illness. Each individual subscale score has a possible range from 10 to 50. The scale values for responses on the CAMI are such that higher scores indicate greater agreement with the factor concept. For example, a person with a tolerant disposition toward the mentally ill would be expected to have higher scores on the benevolence and community mental health ideology factors and lower scores on the authoritarian and social restrictiveness factors. Scale reliability ranges from alpha 0.68 to 0.88 and construct validity also showed the desired result (Taylor and Dear 1981, p. 230).

The survey also contained a modified version of the Bogardus Social Distance Scale (SDS) used in the Adewuya and Makanjuola 2005 study. The SDS was used to assess the participants' desire for social distance towards those with a mental illness and included six questions developing along a Guttman scale of increasing personal intimacy. The six questions ranged along a 4-point Likert scale (1=definitely not, 2=probably not, 3=probably yes, 4= definitely yes). All items on the six questions involved those of various social relationships, such as: marriage, sharing a room, working with someone, maintaining a friendship, conversing with someone and a familial relationship. Bogardus (1925) introduced the original social distance scale for use as an index of the social distance that participants distinguish between themselves and members of different groups defined by nationality, ethnicity, religion, or politics. This scale, or some form of it, has been used in many studies involving varied populations, even including ethnic minorities, majority group members, and occupational groups (Weinfurt & Moghaddam, 2001).

Procedure

Recruitment: Potential UNCW subject pool participants signed up for partial credit towards their introduction to Psychology class at the beginning of the semester on a sign-up sheet posted in the Psychology department building. Older participants were recruited at the New Hanover County Department of Aging (Senior Center). One hundred and twenty surveys were distributed, and 78 returned, with a 65% return rate. Recruitment occurred over two days at the center: during a health fair sponsored by the local hospital and one day during the following week through class instructors. People who were interested were offered a copy of the survey and a self addressed stamped envelope. Participants who did not have ample time to complete the survey, or who chose to do it later, returned the survey by prepaid mail.

Surveys: The survey that consisted of three sections: demographic information (age, gender, education, past experience with or knowledge of mental illness, and past employment in the mental health care field), the CAMI (developed by Taylor and Dear 1981, which measures attitudes toward the mentally ill and has four subscales including authoritarianism, benevolence, social restrictiveness, and community mental health ideology) and a modified version of the Bogardus Social Distance Scale which contains 6 questions designed in a Likert-type style to measure the likelihood one would have a relationship with someone with a mental illness.

Completion of surveys: UNCW Subject Pool participants signed up and attended a single, 30-minute session in a room in the psychology building and completed the surveys at that time. The older participants either completed the survey immediately and returned

directly to the researchers or mailed the survey back to the researchers in the postage paid, self-addressed stamped envelopes attached. Data was collected during February, March and April of 2007. It should be noted that data collection preceded the events at Virginia Tech.

Definition of variables

The first hypothesis examined familiarity with mental illness and attitudes and social distance. Familiarity with mental illness in literature is described in relatively vague terms: "the knowledge of and experience with mental illness" (Corrigan et al, 2001, p.955).Corrigan and colleagues (2001) had participants rank order 12 situations of varying degrees of intimacy that involve people with mental illness in the Level of Contact Report. For the purposes of this study, participants were classified as being familiar or unfamiliar with mental illness according to the following scheme. Familiarity with mental illness was defined as an answer of "yes" on Question 1 (Have you or someone close to you, a close friend or family member, ever had a mental illness?) of the demographics questionnaire and a Likert-score of 4 or higher on Questions 2, 3, or 4 of the demographics section (see Appendix 1). Questions 2-4 of the demographics questionnaire examined the closeness of the mentally ill person to the participant, as well as the degree of knowledge the participant felt he/she had with mental illness due to prior work experience or educational experiences, such as from previous classes. A participant was also classified as being familiar with mental illness if he or she had answered no on question 1, but had rated a 4 or higher on questions 3 or 4.

Social Distance was also treated as a categorical variable. Levels of social distance were categorized according to the format described by the Adewuya and

Makanjuola 2005 study, Low, Medium, and High. A low social distance rating was given for those participants who answered all 6-items ‘desirably’ which were the “definitely yes/probably yes.” An example of an item answered desirably would be “probably yes or definitely yes” to the question, “Would you work on the same job with someone with mental illness?” Medium social distance was given if only one item was answered undesirably (“probably not/definitely not”), and high social distance was if two or more items were answered undesirably.

For those with a previous familiarity, no gender or age differences were expected. Two Independent Samples T-tests were conducted for hypothesis one and two. Participants who were familiar and unfamiliar, Positive Attitude (a continuous variable comprised by the combined scores of the Benevolence and Community Mental Health Ideology subscales of the CAMI), and negative attitude (the combined scores of the Social Restrictiveness and Authoritarianism subscales of the CAMI) scores were examined in order to determine any statistically significant differences among those who had familiarity with persons with mental illness than those who did not have a familiarity. To assess whether social distance and familiarity with mental illness were related, a chi-square goodness of fit was conducted.

In order to examine Hypothesis three, age and attitudes, an Independent Samples T-test was conducted. Age group (older/younger participants), and positive attitude, and negative attitude scores were analyzed in order to examine whether significant differences existed between the college-aged and older adult sample. A chi-square goodness of fit was also conducted in order to examine whether differences existed among the levels of social distance and age (older/younger) variables.

For Hypothesis four, two independent samples T-Tests were conducted by using gender (men/women), and positive attitudes (Benevolence and CMHI subscales of the CAMI), and negative attitude (Social Restrictiveness and Authoritarianism subscales) scores. Men and women were expected to show similar scores on the CAMI subscales, dependent upon gender. Men were expected to score higher on social restrictiveness and authoritarianism (negative attitude subscales of the CAMI), while Women were expected to score higher on benevolence and community mental health ideology subscales (positive attitude subscales of the CAMI). A chi-square goodness of fit was also conducted in order to examine gender and levels of social distance from those with mental illness.

RESULTS

Familiarity with mental illness and attitudes

Participants classified as being familiar with mental illness were expected to have higher positive attitude scores towards mental illness and lower negative attitude scores. An independent samples T-test was conducted to measure Familiarity (yes/no), Positive Attitude (the combined scores of the Benevolence and Community Mental Health Ideology subscales of the CAMI), and negative attitude factors (the combined scores of the Social Restrictiveness and Authoritarianism subscales of the CAMI). A statistically significant relation was found (see Table 3). Participants who were classified as being familiar with mental illness exhibited greater positive attitudes towards those with mental illness than those who indicated no familiarity [$t(146) = 2.23$, $p < .05$].

Familiarity and social distance

Participants who indicated a familiarity with mental illness was expected to show lower social distance (low, medium, high) towards those with mental illness. A chi-square goodness of fit was conducted in order to examine the relationship of familiarity with level of social distance (see Table 3). The results were not significant, indicating no pattern of social distance among familiar and unfamiliar participants [χ^2 (2, n =148) =1.58, $p > .05$].

Age group and attitudes toward mental illness

The older adult sample was expected to show more positive attitudes toward the mentally ill and less negative attitudes due increased opportunities for contact with mental illness. To test this, two independent samples T-tests were conducted (see Table 4). The first t-test between older and younger participants and positive attitude scores (Benevolence and CMHI) revealed no significant differences between older adults and college-aged adults [t (146) = 1.05, $p > .05$]. The second t-test of mean differences on negative attitudes (Social Restrictiveness and Authoritarianism) between older and younger participants revealed a significant difference with older adults exhibiting more negative attitudes than college-aged adults [t (146) = -2.58, $p < .05$].

A chi-square goodness of fit was conducted on age and social distance in order to examine the relation between these groups. A significant relation between age and social distance (low, medium, and high) was found. Data shows a significant difference between the distribution of social distance for older and younger participants. Older participants indicated higher social distance than would be expected if age and social

Table 3. Statistical Analysis conducted on Familiarity vs. Unfamiliarity by Variable

Variables	*Direction*	*Statistics*
Pos. Attitudes	Fam. < Unfam.	t (146) = 2.23, $p < .05$
Neg. Attitudes	Fam. < Unfam.	t (146) = -1.91, $p < .05$
Soc. Distance	N.S.	X^2(2, n =148) =1.58, $p > .05$

Table 4. Statistical Analyses Conducted on Age Group (older/younger) by Variable

Variables	*Direction*	*Statistics*
Familiarity	O > Y	X^2 (1, n = 148) = 5.39, $p < .05$
Pos. Attitudes	N.S	t (146) = 1.05, $p > .05$
Neg. Attitudes	O > Y	t (146) = -2.58, $p < .05$
Soc. Distance	O > Y	X^2 (1, n=116) = 5.07, $p < .05$

distance were independent and younger participants had lower social distance than would be expected [χ^2 (2, n=148) = 9.29, $p < .05$].

Gender and attitudes toward mental illness

Two one-tailed independent samples T-tests were conducted to verify if women held more positive attitudes and scored lower on the negative attitude factors (see Table 5). Women across age groups scored significantly higher on positive attitude subscales of the CAMI than did males [t (146) = -3.26, $p < .05$]. Male participants of both age groups scored significantly higher on negative attitude subscales of the CAMI than did women [t (146) = 1.84, $p<.05$]. A chi-square goodness of fit was conducted in order to see if women were more likely to be classified as having low social distance from those with a mental illness. No significant differences were found with gender and social distance [χ^2 (2, n = 148) = 4.90, $p > .05$].

Descriptive Results

Six independent samples T-tests were conducted on Questions 5-10 of the Questionnaire in order to determine whether significant differences existed between older adults and college-age participants on variables related to the mental healthcare field, such as allowing more tax money and insurance to pay for treatment, and the influence of pharmaceutical commercials on television. No significant differences were found among older adults and college-age participants on question 5 of the Questionnaire, "Please rate your agreement with the following statement: I would be willing to put more tax money towards the mental healthcare field" [t (146) = -.70, $p > .05$]. There were also no significant differences found between older adults and college-age participants on question 6 of the Questionnaire, "Please rate your agreement with the following

Table 5. Statistical Analyses Conducted on Gender by Variable

Variables	*Directions*	*Statistics*
Pos. Attitudes	F > M	t (146) = -3.86, $p<.05$
Neg. Attitudes	F < M	t (146) = 1.84, $p < .05$
Soc. Distance	N.S.	$X^2(2, n = 148) = 4.90$, $p > .05$

statement: If I had a mental illness, I would not hesitate to find or seek professional help" [$t\ (146) = -1.87$, $p > .05$]. Question 7 of the Questionnaire, "Please rate your agreement: If I had a mental illness, I wouldn't hesitate to tell a friend", revealed no significant differences among older adults and college-age participants [$t\ (146) = -.78$, $p > .05$]. Question 8 on the Questionnaire, "If you had to seek professional help, would you allow your insurance company to pay for services", did not reveal significant differences between the two older adult and college-age participants [$t\ (146) = -.33$, $p > .05$]. A significant difference was found between older adults and college-age participants on question 9 of the Questionnaire, "How frequently have you seen pharmaceutical commercials advertising products for disorders such as depression on television." College-age participants ($\underline{M} = 4.17$, $SD = .90$) reported viewing significantly more pharmaceutical commercials than older adults ($\underline{M} = 3.68$, $SD = 1.42$), $t\ (146) = 2.49$, $p < .05$. No significant differences were found among older adults and college-age participants on question 10 of the Questionnaire, "How much have those advertisements contributed to your current perceptions about mental illness" [$t\ (146) = 1.31$, $p > .05$].

DISCUSSION

Study findings provided additional information regarding ways in which older and younger people view people with mental illness. Findings lend support to the contact hypothesis, originally proposed by Allport in 1954. Those participants who indicated familiarity with mental illness exhibited significantly more positive and less negative attitudes towards those with mental illness than did those participants who were not familiar. The term familiarity in this context is known as the knowledge of and experience with those with mental illness. Although this study categorized participants

dichotomously with respect to familiarity, the degree of familiarity can range from watching a television portrayal of someone with mental illness, having a friend with mental illness, or having a mental illness oneself. If familiarity had been measured on a continuum, results may have been more informative. Past research has found that familiarity is enhanced by an array of factors such as the number of individuals known, length of time known, degree of intimacy, and the degree of pleasantness of the interaction (Markas, 1993). This study attempted to assess the degree of familiarity with mental illness across participants. Future studies may want to concentrate more on these qualitative and quantitative factors of familiarity in order to determine if it is, in fact, the quality of contact and the contact situations themselves that are essential in determining one's attitudes toward mental illness, or if it is simply some contact versus non at all that produces these effects. The stability of the effects of contact on people's attitudes toward mental illness should also be examined; i.e., will these positive attitudes resulting from contact continue to exist across gender, age and education barriers?

Past research has proposed that those who endorse stigmatizing attitudes are more likely to socially distance themselves from those with mental illness. This study supports these findings. Older adults exhibited significantly greater negative attitudes towards those with mental illness, and at the same time were shown to exhibit significantly greater social distance from those with a mental illness. Past research has also shown that having familiarity/experience of having known someone or experienced a mental illness oneself makes a crucial difference in the finding of whether or not someone is likely to be more or less socially distant from those whom experience a mental illness. This research, again, does not support these findings. A key finding of

this study is that older adults were found to be significantly more familiar with those with mental illness. Although, past research suggested those with greater familiarity would be expected to have greater positive attitudes, this is not true of this study. There are a variety of possible explanations for this unexpected difference. The social distance scale used in this study may have introduced demand characteristics, but if so, the demand characteristics appear to have operated more among younger than older participants. That is to say, if findings are a function of demand characteristics, then younger participants are more sensitive to them and older participants may simply be responding more honestly. This scale is only one measure of attitudes, and future research should determine if these attitudes transfer to actual behaviors and if so, to what degree. Future research may aim to examine the link between perceived likelihood of violence and resulting social distance from those with a mental illness. The degree to which the attributions of stability and/or controllability of mental illness has in the formation of negative attitudes toward those with mental illness may also be examined in future research to determine whether these particular attributions have any major impact of the increase in social distance from mental illness. After all, it is these attributions that people hold toward those with mental illness that affect their attitudes towards others with mental illness, and it is understanding what underlies the causes of these attributions that can hold the key to anti-stigma strategies in the future.

Prevalence rates of mental illness, among the young people, ages 15-21, have increased significantly in the past 50 years (Mowbray et al, 2006). This increase could explain the lower social distance in young adults. Are these differences in age the result of a cohort effect? The college-age participants sampled in this study were children of the

1980's-90, whereas the older adult participants were children of the 1930's-1950. Is it possible that these differences in findings are related to the differences in social norms of the eras in which the participants grew up? Or perhaps, these age differences are more complex, in that these generally more negative attitudes toward mental illness by the older participants are due to some form of self-preservation. Conceivably, these older adults are more concerned with the fear or threat of violence that it produces more social distance from others; therefore, these older adults yield greater defensive attributions and may also be attributing others' mental illnesses to more stable factors within those with the illness. If this is the case, are anti-stigma strategies oriented toward older adult education likely to have an effect in decreasing these already formed attitudes? Also, by not using age as a continuous variable and sampling people of all ages, we are unable to draw conclusions about mid-life or use statistical procedures that may be more informative.

This study appears to validate others' findings on Taylor and Dear's (1981) Community Attitudes toward the Mentally Ill (CAMI) with regard to gender differences on the subscales: men scored significantly higher on the authoritarian and social restrictiveness subscales (negative attitudes), while women scored significantly higher on the benevolence and community mental health ideology subscales (positive attitudes). It appears that women in both age groups exhibited more tolerant attitudes toward those with mental illness, while men exhibited less tolerance. Yet questions still remain as to why these gender differences continue to exist across age and time. Are these more tolerant attitudes toward mental illness due to the social roles that women play in society, such as the mother, wife and provider? Or are these attitudes due to the fact that women

are more likely to become labeled as mentally ill, thus related to the sex differences that exist in factors such as emotional expressiveness, help-seeking or method of presentation? Therefore, do women, in fact, have generally more tolerant attributions towards those with mental illness and are their attributions about the causes of mental illness the key to these more positive attitudes? Do women attribute the causes of mental illness to factors that are less stable and out of the control of the individual; therefore, they feel more sympathy towards the person with illness? Future research should investigate how these negative attitudes are developed and maintained in men. Yet research should also be conducted in order to attempt clarification of the maintenance of these positive attitudes towards mental illness held by women. One should note that the sample used in this study was predominantly women ($n = 106$ out of 148), therefore a limitation of this study would be the lack of diversity of the sample itself. Another concern then is the lack of diversity in ethnicity within the sample as well, thus raising the question of whether or not the study could generalize across cultures.

A significant difference was found among the years of education in the population sample of this study. College-aged participants ($M= 14.23$, $SD = 1.02$) significantly differed in the number of years of education from the older adult participants ($M = 11.65$, $SD = 5.67$). It should be noted that the standard deviation of number of years of education is much higher in the older adult sample than in the college-age sample. This variability could account for the differences found in regard to social distance and age. Previous studies have supported that older participants of lower educational level have more negative attitudes and increased social distance from those with mental illness. A limitation to this is that there may be more individual differences within the studies'

sample that could account for the findings. Using this more diverse education sample may also better generalize to the entire community. Future research may want to examine college graduates (with at least a bachelor's degree) in both older and younger samples in order to determine whether education is a key component in developing more positive attitudes toward the mentally ill. The types of education provided about mental illness should also be more closely scrutinized in order to resolve if differences can be found in subsequent attitudes.

This research can be potentially valuable for both the general population and perhaps even for counselors and therapists. Knowing clients' opinions and attitudes towards mental health and mental illness can serve as a stepping stone for being able to serve the clients' attributions, expectations and beliefs about the entire counseling or therapy experience as well as being able to understand more about their willingness to seek professional help.

Though many findings were supported with this research, one is left with many questions as to the root of the causes of mental illness stigma, yet, what is thoroughly evident is the impact stigma has on the healthcare field in the families of those with mental illness, the clients and therapists themselves. Its impact is pervasive and the use of more effective anti-stigma strategies is crucial in the early prevention, intervention and treatment of disorders. It is important that society come to understand those with mental illness and their specific needs despite age, gender or education levels of those in the community. A movement towards understanding attributions and how they inform attitudes toward, educating a more tolerant society, and towards giving more assistance for those with mental illness may promote a more responsive, effective healthcare

system. Reducing this societal stigma is essential for improving the quality of life of people with mental illness.

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Appendix A

Appendix A: Questionnaire and CAMI Subscales

Please circle the appropriate answer to the following questions. Please know that your participation is entirely voluntary and you may stop at any time during these surveys. Do not write your name on any of these materials, as your responses are entirely anonymous.

Gender: Male or Female AGE: ______ Number of years of education: ______

Circle the highest completed: High School Some college Community College

4-yr. degree (college) Master's Other

1. **Have you or someone very close to you (close friend or family member) ever had a mental illness?**

   YES NO

2. **If you answered yes to the above question, please rate on a scale of 1-5, how familiar you believe yourself to be with *that person* (close friend, family member, or yourself).**

1	2	3	4	5
Not at all		Somewhat		Very Familiar

3. **On a scale from 1-5, how familiar do you believe yourself to be with mental illness based on past *educational* experiences, such as from classes?**

1	2	3	4	5
Not at all		Somewhat		Very familiar (with mental illness)

4. **On a scale from 1-5, how familiar do you believe yourself to be with mental illness based on any previous *employment*, such as working with someone with mental illness(es)?**

1	2	3	4	5
Not at all		Somewhat		Very Familiar

5. **Please rate your agreement with the following statement: I would be willing to put more tax money towards the mental healthcare field.**

Strongly Disagree Disagree No Opinion Agree Strongly Agree

6. **Please rate your agreement with the following statement: If I had a mental illness, I would not hesitate to find or seek professional help.**

Strongly Disagree Disagree No Opinion Agree Strongly Agree

7. **Please rate your agreement: If I had a mental illness, I wouldn't hesitate to tell a friend.**

Strongly Disagree Disagree No Opinion Agree Strongly Agree

8. If you had to seek professional help (i.e. counseling), would you allow your insurance company to pay for services?

YES NO

9. How frequently have you seen pharmaceutical commercials advertising products for disorders such as depression on television?

1	2	3	4	5
Not at all		**Somewhat often**		**Very often**

10. How much have those advertisements contributed to your current perceptions about mental illness?

1	2	3	4	5
Not at all		**Somewhat**		**Very Much**

<u>Answer these</u>: Please circle one of the following for each statement from either strongly disagree to strongly agree. *The mentally ill refers to people needing treatment for mental disorders but who are capable of independent living outside of a hospital.*

Statement	**Strongly Disagree**	**Disagree**	**No Opinion**	**Agree**	**Strongly Agree**
One of the main causes of mental illness is a lack of self-discipline and will power.	SD	D	NO	A	SA
The best way to handle the mentally ill is to keep them behind locked doors.	SD	D	NO	A	SA
There is something about the mentally ill that makes it easy to tell them from normal people.	SD	D	NO	A	SA
As soon as a person shows signs of mental disturbance he should be hospitalized.	SD	D	NO	A	SA
Mental patients need the same kind of control and discipline as a young child.	SD	D	NO	A	SA

Statement	Strongly Disagree	Disagree	No Opinion	Agree	Strongly Agree
Mental illness is an illness like any other.	SD	D	NO	A	SA
The mentally ill should not be treated as outcasts of society.	SD	D	NO	A	SA
Less emphasis should be placed on protecting the public from the mentally ill.	SD	D	NO	A	SA
Mental hospitals are an outdated means of treating the mentally ill.	SD	D	NO	A	SA
Virtually anyone can become mentally ill.	SD	D	NO	A	SA
The mentally ill have for too long been the subject of ridicule.	SD	D	NO	A	SA
More tax money should be spent on the care and treatment of the mentally ill.	SD	D	NO	A	SA
We need to adopt a far more tolerant attitude toward the mentally ill in our society.	SD	D	NO	A	SA
Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for.	SD	D	NO	A	SA
We have a responsibility to provide the best possible care	SD	D	NO	A	SA

Statement	Strongly Disagree	Disagree	No Opinion	Agree	Strongly Agree
for the mentally ill.					
The mentally ill don't deserve our sympathy.	SD	D	NO	A	SA
The mentally ill are a burden on society.	SD	D	NO	A	SA
Increased spending on mental health services is a waste of tax dollars.	SD	D	NO	A	SA
There are sufficient existing services for the mentally ill.	SD	D	NO	A	SA
It is best to avoid anyone who has mental problems.	SD	D	NO	A	SA
The mentally ill should not be given any responsibility.	SD	D	NO	A	SA
The mentally ill should be isolated from the rest of the community.	SD	D	NO	A	SA
A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered.	SD	D	NO	A	SA
I would not want to live next door to someone who has been mentally ill.	SD	D	NO	A	SA

Statement	Strongly Disagree	Disagree	No Opinion	Agree	Strongly Agree
Anyone with a history of mental problems should be excluded from taking public office.	SD	D	NO	A	SA
The mentally ill should not be denied their individual rights.	SD	D	NO	A	SA
Mental patients should be encouraged to assume the responsibilities of normal life.	SD	D	NO	A	SA
No one has the right to exclude the mentally ill from their neighborhood.	SD	D	NO	A	SA
The mentally ill are far less of a danger than most people suppose.	SD	D	NO	A	SA
Most women who were once patients in a mental hospital can be trusted as babysitters.	SD	D	NO	A	SA
Residents should accept the location of mental health facilities in their neighborhood to serve the needs of the local community,	SD	D	NO	A	SA
The best therapy for many mental patients is to be part of a normal community.	SD	D	NO	A	SA
As far as possible, mental health services should be provided through community based facilities.	SD	D	NO	A	SA

Statement	Strongly Disagree	Disagree	No Opinion	Agree	Strongly Agree
Locating mental health services in residential neighborhoods does not endanger local residents.	SD	D	NO	A	SA
Residents have nothing to fear from people coming into their neighborhood to obtain mental health services.	SD	D	NO	A	SA
Mental Health facilities should be kept out of residential neighborhoods.	SD	D	NO	A	SA
Local residents have good reason to resist the location of mental health services in their neighborhood.	SD	D	NO	A	SA
Having mental patients living within residential neighborhoods might be good therapy but the risks to residents are too great.	SD	D	NO	A	SA
It is frightening to think of people with mental problems living in residential neighborhoods.	SD	D	NO	A	SA
Locating mental health facilities in a residential area downgrades the neighborhood.	SD	D	NO	A	SA

Please answer the following questions according to the scale provided. Place a check in the appropriate box.

Statement	**Definitely Yes**	**Probably Yes**	**Probably Not**	**Definitely Not**
Would you be ashamed if people knew someone in your family has/has had mental illness?				
Would you have a conversation with someone with mental illness without fear?				
Would you work on the same job with someone with mental illness?				
Would you maintain friendship with someone with mental illness?				
Would you share a room with someone with mental illness?				
Would you marry someone with mental illness?				

Footnotes

[1] The figure is from: Challenging two mental illness stigmas: Personal responsibility and dangerousness, by Corrigan, P.W. et al, 2002, *Schizophrenia Bulletin, 28*, 293-307.

[2] The figure is from: How stigma interferes with mental health care, by Corrigan, P. W., 2004, *American Psychologist, 59*, 614-625.