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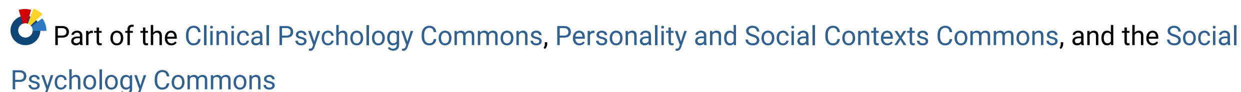

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The University of Southern Mississippi

PERSONALITY, CHARACTER STRENGTHS, EMPATHY, FAMILIARITY AND THE STIGMATIZATION OF MENTAL ILLNESS

by

Jessica Shanna James

A Thesis
Submitted to the Graduate School
of the University of Southern Mississippi
in Partial Fulfillment of the Requirements
for the Degree of Master of Arts

Approved:

Dr. Randolph C. Arnau
Committee Chair

Dr. Bradley A. Green

Dr. Christopher T. Barry

Dr. Karen S. Coats
Dean of the Graduate School

May 2015

ABSTRACT

PERSONALITY, CHARACTER STRENGTHS, EMPATHY, FAMILIARITY
AND THE STIGMATIZATION OF MENTAL ILLNESS

by Jessica Shanna James

May 2015

The stigma associated with mental illness is pervasive and detrimental. The aim of the current study was to assess individual characteristics that may be positively and negatively associated with the stigmatization of mental illness. Two-hundred fifty-nine undergraduate students from the University of Southern Mississippi completed measures of the Big Five personality traits (i.e., Agreeableness, Extraversion, Conscientiousness, Neuroticism, and Openness to Experience), Dark Triad personality traits (i.e., Machiavellianism, Narcissism, and Psychopathy), selected character strengths (i.e., Open-mindedness, Perspective, Bravery, Integrity, Kindness, Social Intelligence, Fairness, Forgiveness and Mercy, and Hope), Empathy, and Familiarity with mental illness. Participants also completed measures of stigmatizing attitudes (i.e., perceived dangerousness, personal responsibility attributed, and desired social distance) associated with targets described in vignettes as having a mood disorder (i.e., Major Depressive Disorder), a personality disorder (i.e., Borderline Personality Disorder), a psychotic disorder (i.e., Schizophrenia), and a chronic medical illness (i.e., Leukemia). Results suggest higher order factors of stigmatization that encompass the different attitudes assessed for each condition and a higher order factor for stigmatization of mental illness that includes stigma of each mental illness assessed. Empathy, Narcissism, and Fairness were found to be related to the stigmatization of mental illness. Additionally, stigma levels, specific stigmatizing attitudes, and individual characteristics associated with

stigmatizing attitudes were found to differ based on disorder assessed. Implications and future directions are discussed.

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CHAPTER I

INTRODUCTION

Mental illness is a serious health concern in the United States (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013). Mental illness is described as "a syndrome characterized by clinically significant disturbance in an individual's cognition, emotional regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning" (American Psychiatric Association [APA], 2013, p. 20). Classifications for mental illnesses are found in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*) and have been classified according to type, ranging from mood disorders to personality disorders to psychotic disorders, along with many other classifications.

Approximately 42.5 million adults, or 18.2% of the adult population, experience a mental illness each year (SAMHSA, 2014). Mental illness is typically associated with distress and disability (e.g., APA, 2013). Despite this, only 40% of those suffering from mental illness actually receive treatment (SAMHSA, 2013). Furthermore, the people who do receive treatment may not adhere to it (Phelan & Basow, 2007). One commonly cited reason for not seeking or adhering to treatment is stigma (Link, Phelan, Besnahan, Stueve, & Pescosolido, 1999; Mojtabai et al., 2011; Phelan & Basow, 2007). In a nationally representative sample, 97.4% cited attitudinal or evaluative barriers to seeking treatment with 9.1% specifically citing stigma (Mojtabai et al., 2011). Furthermore, 81.9% reported dropping out of treatment due to attitudinal or evaluative barriers with 21.2% specifically citing stigma (Mojtabai et al., 2011).

Mental illness may thus not only be harmful in itself, but the stigma associated with mental illness has the potential to further increase its harm (Feldman & Crandall,

2007). The stigmatization of mental illness is a known problem that negatively affects individuals with mental illness, their families, their treatment, and society as a whole (e.g., Feldman & Crandall, 2007; Holmes, Corrigan, Williams, Canar, & Kubiak, 1999; Link et al., 1999). Less is known, however, about the characteristics of individuals who hold these harmful views. By assessing individual characteristics such as personality traits, character strengths, empathy, and familiarity with mental illness, this study aims to determine which combinations of individual characteristics are positively and negatively associated with the propensity to stigmatize people with mental illness. This understanding will add to current knowledge about personality traits, character strengths, empathy, familiarity with mental illness, and the stigmatization of mental illness.

Stigma

Stigma is described as “a mark separating individuals from one another based on a socially conferred judgment that some persons or groups are tainted and 'less than'” (Pescosolido, Medina, Martin, & Long, 2013, p. 431). The stigmatization process includes four components: labeling, stereotyping, prejudice, and discriminating (Angermeyer & Matschinger, 2005; Phelan & Basow, 2007). First, an individual is labeled as “different” and treated negatively (Feldman & Crandall, 2007; Penn et al., 1994). Next, stereotypes are formed as assumed knowledge about a social group becomes widely endorsed (Corrigan, Edwards, Green, Diwan, & Penn, 2001). Prejudice arises when people develop emotional reactions to the stereotypes they believe are true (Corrigan et al., 2001), leading to discrimination (Corrigan et al., 2001; Phelan & Basow, 2007).

The stigmatization process has been applied to the study of perceptions of mental illness and the experiences of individuals with mental illness. Labeling is a known

predictor of stigma (Phelan & Basow, 2007; Wang & Lai, 2008; Yap, Reavley, Mackinnon, & Jorm, 2013). Individuals are often labeled as mentally ill based on deviant behavior (Angermeyer & Matschinger, 2005; Phelan & Basow, 2007) but may be labeled even without displaying abnormal behavior (Penn et al., 1994). Labeling in itself is not inherently negative; it only becomes negative when it is associated with damaging stereotypes (Phelan & Basow, 2007; Yap et al., 2013). After an individual is labeled as having a mental illness, negative stereotypes may be activated (Canu, Newman, Morrow, & Pope, 2008). These stereotypes include beliefs that people with mental illness are dangerous and that they are personally responsible for the development of their mental illness (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003; Link et al., 1999). These stereotypes may arise from a range of sources, including personal experience with people with mental illness and media portrayals of mental illness. Because people with mental illness are as varied as any other individuals, these experiences may unfairly generalize all people with mental illness. For example, people with mental illness are frequently portrayed in mass media, but these depictions tend to be inaccurate and negative (Wahl, 1992). Furthermore, these depictions may be influential in the formation of stereotypes and resulting attitudes toward mental illness (Wahl, 1992; Wahl & Harmon, 1989). Prejudice and discrimination may ensue from these stereotypes, as some individuals desire social distance from people with mental illness and may thus be less willing to provide housing or employment to people with mental illness (Anagnostopoulos & Hantzi, 2011; Brown, 2012; Corrigan et al., 2001, 2003; Phelan & Basow, 2007).

The effects of stigma are detrimental (Feldman & Crandall, 2007; Holmes et al., 1999; Link et al., 1999). Socially, people with mental illness may limit their social interactions, show impaired adjustment, have strained relationships, lose their social

status, and desire to keep their illness a secret in order to avoid rejection and stigmatization (Canu et al., 2008; Feldman & Crandall, 2007; Kranke, Floersch, Townsend, & Munsen, 2010; Penn, Kommana, Mansfield, & Link, 1999). Self-stigma, or the internalization of negative social responses and rejection, may lead to feelings of shame and internalized rejection (Kranke et al., 2010). Self-stigma has also been associated with low self-esteem and low life satisfaction (Canu et al., 2008; Feldman & Crandall, 2007; Kranke et al., 2010; Penn et al., 1994). Stigma also affects treatment and has been related to reluctance to seek help, unwillingness to adhere to treatment, and low self-efficacy (Canu et al., 2008; Feldman & Crandall, 2007; Link et al., 1999; Penn et al., 1999; Yap et al., 2013). The stress that accompanies feeling stigmatized may also contribute to relapse (Penn et al., 1994). Prejudice and discrimination arise as individuals showing less willingness to hire, house, and interact with people with mental illness (Corrigan et al., 2001; Feldman & Crandall, 2007; Kranke et al., 2010).

Although the examples of stigmatizing attitudes toward people with mental illness are plentiful, the current study examines three specific dimensions of stigma: the perception that people with mental illness are dangerous, the belief that people with mental illness are responsible for their condition, and the desire to maintain social distance from people with mental illness. Perceptions that people with mental illness are dangerous, violent, and unpredictable are commonly held stereotypes that are central to stigma (e.g., Corrigan, 2004; Link et al., 1999; Penn et al., 1999; Phelan & Basow, 2007). This stereotype may lead to fear, avoidance, and discrimination (Bos, Pryor, Reeder, & Stutterheim, 2013; Feldman & Crandall, 2007). Another common stereotype is that people with mental illness are in control of their illness or that their illness is due to character weakness or incompetence (e.g., Corrigan, 2004; Feldman & Crandall, 2007;

Link et al., 1999; Wright, Jorm, & Mackinnon, 2011). These beliefs may lead to anger and rejection (Bos et al., 2013; Feldman & Crandall, 2007). Stigmatizing attitudes, such as stereotypes of perceived dangerousness and personal responsibility, are predictive of social distance (Feldman & Crandall, 2007; Link et al., 1999). Desire for social distance is often studied as a proxy for discrimination, a common outcome of stigmatization (Angermeyer & Matschinger, 2005; Corrigan et al., 2001), and may be evidenced in individuals avoiding, rejecting, and refusing to hire or rent to people with mental illness (Bos et al., 2013; Corrigan, 2004; Feldman & Crandall, 2007).

Stigmatization of Different Mental Illnesses

Several studies have examined stigma by using a target with Schizophrenia (e.g., Corrigan et al., 2001, 2003). However, it is believed that the stigmatization of mental illness may be unique to the disorder being examined (Feldman & Crandall, 2007). Furthermore, there may differences in stigmatization based on different classifications of illness (e.g., mood disorder, personality disorder, psychotic disorder). It has been proposed that different mental illnesses may elicit different levels of stigmatization based on different characteristics such as an illness's visibility, its perceived controllability, and the public's understanding of the illness (cf. Canu et al., 2008). Feldman and Crandall (2007), for example, explored stigmatization across forty diagnoses and although most diagnoses evoked rejection, there was a range of attitudes. For example, when given a diagnostic label and brief definition of the disorder, Borderline Personality Disorder was ranked as more likely to elicit desire for social distance than Paranoid Schizophrenia which was ranked as more likely to elicit desire for social distance than Major Depressive Disorder (Feldman & Crandall, 2007). Furthermore, previous research comparing perceptions of Depression and Schizophrenia have shown moderate differences in

perceived dangerousness, no differences in attributions personal responsibility, and small to moderate differences in desire for social distance (Link et al., 1999; Pescosolido et al., 2013; Wright et al., 2011). No previous research has examined the differences between perceptions of Borderline Personality Disorder and perceptions of Major Depressive Disorder or Schizophrenia, but it has been suggested that the stigma associated with Borderline Personality Disorder is severe (Aviram, Brodsky, & Stanley, 2006; Feldman & Crandall, 2007).

The stigmatization of mental illness is a complex, multidimensional problem with many negative consequences. However, less is known about who is most likely to hold these views. As such, the purpose of the current study was to examine the relationship between individual characteristics (i.e.,. personality, character strengths, empathy, familiarity with mental illness) and the stigmatization of different mental illnesses.

The Big Five Personality Traits

Personality researchers have approached general consensus on using the five-factor model of personality, or the “Big Five” personality dimensions (Goldberg, 1981), as a general taxonomy for personality traits (John & Srivastava, 1999). The Big Five describe the broadest dimensions of personality with each dimension being comprised of more specific facets (e.g., John & Srivastava, 1999). These dimensions have been broadly named Extraversion, Agreeableness, Conscientiousness, Neuroticism, and Openness to Experience (e.g., John & Srivastava, 1999). These five factors have been shown to be comprehensive, replicable, stable across time for adults, and have convergent and discriminant validity across observers (i.e., self- and peer-ratings) and instruments (Goldberg, 1990; John & Srivastava, 1999; McCrae & Costa, 1987; McCrae & John, 1992). Strengths of this model include its comprehensiveness, simplicity, cross-cultural

applicability, and predictive nature (McCrae & John, 1992; Zillig, Hemenove, & Dienstbier, 2002)

Extraversion

Extraversion is a personality trait that focuses on affect and behavior (Zillig et al., 2002). The tendency to experience positive emotions is the core of Extraversion and includes characteristics such as warmth, affection, cheerfulness, optimism, and enthusiasm (John & Srivastava, 1999; McCrae & Costa, 1987; McCrae & John, 1992; Zillig et al., 2002). It is also characterized by talkativeness, assertiveness, sociability, activeness, excitement or fun seeking, ambitiousness, and expressiveness (John & Srivastava, 1999; McCrae & Costa, 1987; McCrae & John, 1992; Zillig et al., 2002). Individuals low in Extraversion tend to be shy and reserved (McCrae & John, 1992).

Agreeableness

Agreeableness focuses on cognition and behavior (Zillig et al., 2002). Agreeableness describes the tendency to be oriented toward people and includes elements such as trustworthiness and tender-mindedness (John & Srivastava, 1999; McCrae & Costa, 1987; McCrae & John, 1992; Zillig et al., 2002). It is also characterized as being warm, altruistic, good-natured, forgiving, cooperative, and modest (John & Srivastava, 1999; McCrae & John, 1992; Zillig et al., 2002). People low in Agreeableness tend to be oriented against others, self-centered, skeptical, callous, hostile, unsympathetic or indifferent to others, uncooperative, and critical (McCrae & Costa, 1987; McCrae & John, 1992).

Conscientiousness

Conscientiousness is best described via behavior (Zillig et al., 2002). Conscientiousness is described as being competent, self-disciplined, deliberate,

purposeful, careful, thorough, and focused on achievement (McCrae & Costa, 1987; McCrae & John, 1992; Zillig et al., 2002). It is also described as being orderly, responsible, moralistic and ethical (John & Srivastava, 1999; McCrae & Costa, 1987; McCrae & John, 1992; Zillig et al., 2002). Individuals low in Conscientiousness are typically impulsive and self-indulgent (McCrae & Costa, 1987; McCrae & John, 1992).

Neuroticisism

Neuroticism is described as the tendency to experience negative affect, including feelings of anxiety, angry hostility, depression, worry, distress, guilt, tenseness, and mistrust (McCrae & Costa, 1987; McCrae & John, 1992; Zillig et al., 2002). It involves self-consciousness, insecurity, low self-esteem, and being temperamental (McCrae & Costa, 1987; McCrae & John, 1992; Zillig et al., 2002). Neuroticism also includes irrational thinking and beliefs, vulnerability, inappropriate coping responses, and impulsiveness (McCrae & Costa, 1987; McCrae & John, 1992; Zillig et al., 2002). Individuals low in Neuroticism are usually calm, relaxed, even-tempered, and not easily upset (John & Srivastava, 1999; McCrae & John, 1992).

Openness to Experience

Openness to Experience (previous names include Culture and Intellect) includes both cognitions and affect (John & Srivastava, 1999; Zillig et al., 2002). Openness involves having broad interests, being perceptive, being insightful, being independent-minded, and showing originality (John & Srivastava, 1999; McCrae & Costa, 1987; McCrae & John, 1992). It also includes having fantasies and ideas, being imaginative and creative, and enjoying variety (McCrae & Costa, 1987; McCrae & John, 1992; Zillig et al., 2002). Furthermore, Openness involves values, an appreciation of aesthetics, and being in tune with one's feelings, sensations, and experiences (McCrae & Costa, 1987;

McCrae & John, 1992; Zillig et al., 2002). People low in Openness are typically conservative and conventional (McCrae & John, 1992).

The Big Five and Stigmatization of Mental Illness

Two different explanations have dominated the explanation of individual differences in prejudicial attitudes – differences in individuals' personalities and differences in individuals' group membership (Ekehammar & Akrami, 2003, 2007; Reynolds, Turner, Haslam, & Ryan, 2001). The former personality approach "is based on the contention that prejudice is not solely a function of the social environment, social-group membership, or social identity, but rather a function of internal attributes of the individual" (Ekehammer & Akrami, 2003, p. 450). Thus, prejudicial attitudes can be explained in part by individual characteristics. Right-wing authoritarianism and social dominance orientation have often been studied with prejudice, but their categorization as personality traits has been questioned (Sibley & Duckitt, 2008). More recently, the Big Five has been used as a model to study the relationship between personality and prejudice.

Characteristics of the Big Five personality traits lend themselves to the study of prejudice and the stigmatization of mental illness. Extraversion may be related to less stigmatizing attitudes because it involves affection and sociability (McCrae & Costa, 1987; McCrae & John, 1992). Although Extraversion has been found to have no relationship with prejudice (Ekehammar & Akrami, 2003, 2007), it has demonstrated a small to moderate negative relationship to the stigmatization of mental illness (Canu et al., 2008). Agreeableness may also be related to less stigmatizing attitudes because it involves being oriented toward others and altruistic (McCrae & Costa, 1987; McCrae & John, 1992). Agreeableness has been negatively associated with both prejudice

(Ekehammar & Akrami, 2003, 2007; Graziano, Bruce, Sheese, & Tobin, 2007; Saucier & Goldberg, 1998; Sibley & Duckitt, 2008) and the stigmatization of mental illness (Brown, 2012; Canu et al., 2008). However, the size of the effect has been mixed, ranging from small to large. Conscientiousness may be related to less stigmatizing attitudes because it is represented as being moralistic and ethical (McCrae & Costa, 1987; McCrae & John, 1992). Previous literature has found Conscientiousness to have small relationships with prejudice (Sibley & Duckitt, 2008) and with the stigmatization of mental illness (Canu et al., 2008). However, while Sibley and Duckitt (2008) found a positive relationship, Canu and colleagues (2008) found a negative association, and Ekehammar and Akrami (2003, 2007) found no relationship. Neuroticism may be associated with more stigmatizing attitudes because it is related to mistrust and hostility (McCrae & Costa, 1987; McCrae & John, 1992). Neuroticism has been found to have small relationships with prejudice (Saucier & Goldberg, 1998) and with the stigmatization of mental illness (Brown, 2012). However, while Saucier and Goldberg (1998) found a negative relationship, Brown (2012) found a positive association, and Canu and colleagues (2008) and Ekehammar and Akrami (2003, 2007) found no relationships. Lastly, Openness to Experience may be associated with less stigmatizing attitudes because it involves being perceptive and in tune with one's feelings and experiences (McCrae & Costa, 1987; McCrae & John, 1992). Openness to Experience has been found to have a negative association with prejudice (Ekehammar & Akrami, 2003, 2007; Sibley & Duckitt, 2008) and the stigmatization of mental illness (Brown, 2012; Ekehammar & Akrami, 2003). However, the size of the effect has been mixed, ranging from small to large. The mixed findings found in the literature suggest that the relationships between the Big Five personality traits and the stigmatization of mental illness should be further explored.

The Dark Triad Personality Traits

The Dark Triad refers to antagonistic personality traits that are related to psychological harm and are destructive to others (Jones & Figueredo, 2013). These traits are part of a socially injurious character with behavioral tendencies toward self-promotion, emotional unresponsiveness, deceit, and aggression (Paulhus & Williams, 2002). The Dark Triad encompasses three personalty traits: Narcissism, Psychopathy, and Machiavellianism (Paulhus & Williams, 2002). The underlying elements associated with these traits are interpersonal manipulation and callous affect (Jones & Figueredo, 2013; Jones & Paulhus, 2014). Interpersonal manipulation involves lying, an inflated self-worth, the use of coercion, and dishonesty (Jones & Figueredo, 2013). Callous affect involves a lack of concern or remorse for others and their well-being (Jones & Figueredo, 2013). These two characteristics comprise the core of an antagonistic personality (Jones & Figueredo, 2013).

Although Narcissism, Psychopathy, and Machiavellianism share the same core characteristics, each trait in the Dark Triad has distinct behaviors, attitudes, and beliefs, and show unique correlates with different outcomes and should thus each be considered independently (Jones & Figueredo, 2013).

Narcissism

Narcissism is characterized by grandiosity, entitlement, dominance, and superiority (Paulhus & Williams, 2002). It is strongly related to disagreeableness, extraversion, and antagonism (Maples, Lamkin, & Miller, 2013; Paulhus & Williams, 2002). Narcissism describes an egotistical portrayal of the manipulativeness and callousness inherent in the Dark Triad by adding an inflated sense of self to the core characteristics (Jones & Figueredo, 2013; Jones & Paulhus, 2014). The grandiose identity

that illustrates Narcissism typically translates into attributing leadership or authority to oneself and maintaining a sense of entitlement (Jones & Paulhus, 2014; Maples et al., 2013). People high in Narcissism exaggerate their positive qualities and manipulate others to obtain ego validation with no concern for others (Jones & Figueredo, 2013). In efforts to reinforce their egos, these people are self-deceptive, may become aggressive if threatened, and may engage in self-destructive behaviors (Jones & Paulhus, 2014).

Psychopathy

Psychopathy is illustrated by high impulsivity and thrill-seeking and low empathy and anxiety (Paulhus & Williams, 2002). It is strongly related to disagreeableness, antagonism, and low conscientiousness (Paulhus & Williams, 2002; Maples et al., 2013). Psychopathy describes an impulsive and antisocial portrayal of the manipulativeness and callousness characteristic of the Dark Triad by adding a short-term outlook and antisocial attitudes (Jones & Figueredo, 2013). Psychopathy pairs antagonistic behaviors and attitudes with impulsivity or disinhibition, often leading to antisocial and criminal behavior (Jones & Paulhus, 2014; Maples et al., 2013).

Machiavellianism

Machiavellianism involves a strategically manipulative personality (Jones & Paulhus, 2014; Paulhus & Williams, 2002). Machiavellianism describes a cold, calculating, strategic portrayal of the manipulativeness and callousness characteristic of the Dark Triad by adding a strategic orientation to reputation maintenance (Jones & Figueredo, 2013; Jones & Paulhus, 2014). People high in Machiavellianism tend to be calculating, long-term manipulators who lack remorse (Jones & Figueredo, 2013). These people tend to plan, build alliances, and focus on strategically building their own reputations (Jones & Paulhus, 2014).

The Dark Triad and Stigmatization of Mental Illness

As previously stated, one explanation for differences in prejudicial attitudes is differences in individual personality factors (e.g., Ekehammar & Akrami, 2003). While studies accumulate relating prejudice to traditional personality factors (e.g., the Big Five personality traits), other "darker personality variables" may also be important in understanding prejudicial attitudes as prejudice may represent maladjustment (Hodson, Hogg, & MacInnis, 2009, p. 687).

Only one study (Hodson et al., 2009) has been published on the relation between Dark Triad personality traits and generalized prejudice. Hodson and colleagues (2009) found Narcissism, Psychopathy, and Machiavellianism to be positively correlated with prejudice. No research has been published on the association between Dark Triad personality traits and the stigmatization of mental illness. A relationship is hypothesized to exist because Dark Triad personality traits have been repeatedly associated with antisocial attitudes and behavior (Jones & Paulhus, 2014; Maples et al., 2013). Additionally, characteristics of Dark Triad personality traits lend themselves to potentially prejudicial attitudes and, by extension, may be related to stigmatization of mental illness. Specifically, the grandiosity and superiority inherent in Narcissism, the antagonism and lack of empathy illustrative of Psychopathy, and the manipulativeness and lack of remorse characteristic of Machiavellianism are possibly key elements related to prejudice and stigmatization (Jones & Figueredo, 2014; Paulhus & Williams, 2002).

Character Strengths

Character strengths are considered the ingredients to good character and a fulfilling life (Peterson & Seligman, 2004). The study of such strengths is a focus in the field of positive psychology, which seeks to study positive experiences, individual traits,

and what makes life worth living (Peterson & Park, 2003; Seligman & Csikszentmihalyi, 2000). Peterson and Seligman (2004) distinguish three levels of good character: virtues, character strengths, and situational themes. Virtues are the “core characteristics valued by moral philosophers and religious thinkers” and include wisdom, courage, humanity, justice, temperance, and transcendence (Peterson & Seligman, 2004, p. 13). Character strengths are the processes behind these virtues (Peterson & Seligman, 2004). Situational themes are the specific behaviors that can reveal a person's character strengths in a situation (Peterson & Seligman, 2004). Situational themes are context-specific and not considered trait-like (Peterson & Seligman, 2004). For this reason, the current study focuses on the trait-like character strengths that illustrate virtues.

Character strengths are positive traits related to thoughts, feelings, and behaviors linked to well-being (Park, Peterson, & Seligman, 2004). They are dimensional in nature and can be measured as individual differences as they can range from being absent to being excessive (Park et al., 2004; Peterson, 2006). Furthermore, these character strengths have been shown to exist across cultures (cf. Seligman, Steen, Park, & Peterson, 2005).

Peterson and Seligman (2004) suggest twenty-four strengths that are theoretically illustrative of one of six virtues (i.e., wisdom and knowledge, courage, humanity, justice, temperance, and transcendence). These character strengths are all theorized to be related to well-being and life satisfaction (Park et al., 2004). Evidence for links between these character strengths and the cultivation of a “good life” that contributes to life satisfaction are reviewed by Peterson and Seligman (2004), and such evidence forms the basis for giving these traits the label “character strengths.”

In the current study, the following nine character strengths are hypothesized to be negatively related to the propensity to stigmatize people with mental illness: Open-Mindedness, Perspective, Bravery, Integrity, Kindness, Social Intelligence, Fairness, Forgiveness and Mercy, and Hope. Each of these will be described, organized within the context of the virtues with which they are theorized to be related.

Wisdom and Knowledge

Wisdom is a cognitive virtue that illustrates the learning and usage of knowledge (Peterson & Seligman, 2004). This virtue includes the strengths of Creativity, Curiosity, Open-Mindedness, Love of Learning, and Perspective (Peterson & Seligman, 2004). Open-Mindedness and Perspective are discussed here.

Open-Mindedness. Open-Mindedness, judgment, or critical thinking involves "thinking things through and examining them from all sides; not jumping to conclusions; being able to change one's mind in light of evidence; weighing all evidence fairly" (Peterson & Seligman, 2004, p. 29). People who have this strength actively search for evidence and weigh evidence fairly despite their biases (Peterson & Seligman, 2004). This attitude towards thinking is correlated with improved critical thinking (Stanovich & West, 1997). Open-Mindedness is most likely to happen when the decision is important, not time-sensitive, and can result in a positive outcome (cf. Peterson & Seligman, 2004).

Perspective. Perspective or wisdom involves "being able to provide wise counsel to others; having ways of looking at the world that makes sense to oneself and to other people" (Peterson & Seligman, 2004, p. 29). This strength is ultimately used to promote the well-being of oneself and others (Peterson & Seligman, 2004). Perspective is associated with life satisfaction, and subjective well-being (Ardelt, 1997).

Courage

Courage is an emotional virtue that involves determination to accomplish goals despite obstacles (Peterson & Seligman, 2004). Courage may be considered a corrective virtue in that it is used to counteract struggles (Peterson & Seligman, 2004). Strengths of courage include Bravery, Persistence, Integrity, and Vitality (Peterson & Seligman, 2004). Bravery and Integrity are discussed here.

Bravery. Bravery or valor involves "not shrinking from threat, challenge, difficulty or pain; speaking up for what is right even if there is opposition; acting on convictions even if unpopular; includes physical bravery but is not limited to it" (Peterson & Seligman, 2004, p. 29). Bravery thus involves acting in a way that is good for oneself or others even in the face of danger or unpopularity and raising the moral and social conscience of society (Peterson & Seligman, 2004). Bravery correlates with altruism and involvement in "socially worthy aims" (Peterson & Seligman, 2004, p. 219; Shepela et al., 1999).

Integrity. Integrity, authenticity, or honesty involves "speaking the truth but more broadly presenting oneself in a genuine and acting in a sincere way; being without pretense; taking responsibility for one's feelings and actions" (Peterson & Seligman, 2004, p. 29). Integrity thus involves being true to oneself (Peterson & Seligman, 2004). Integrity correlates with measures of psychological well-being and positive interpersonal outcomes (cf. Peterson & Seligman, 2004; Ryan & Deci, 2000).

Humanity

Humanity is an interpersonal virtue that involves befriending and taking care of others (Peterson & Seligman, 2004). Strengths classified in this virtue are thus interpersonal in nature and occur in one-to-one relationships (Peterson & Seligman,

2004). Humanity includes the strengths of Love, Kindness, and Social Intelligence (Peterson & Seligman, 2004). Kindness and Social Intelligence are discussed here.

Kindness. Kindness, generosity, compassion, or altruism involves "doing favors and good deeds for others; helping them; taking care of them" (Peterson & Seligman, 2004, p. 29). Individuals who exhibit Kindness view others as being worthy of attention and affirmation and are typically willing to help others without seeking benefits for themselves (Peterson & Seligman, 2004). Kindness is associated with volunteerism which is linked to several positive mental and physical health outcomes (Omoto & Snyder, 1995; Peterson & Seligman, 2004). This strength is relatively stable throughout an individual's lifetime and enabled by feelings of empathy and sympathy, moral reasoning, social responsibility, and positive mood (Peterson & Seligman, 2004).

Social Intelligence. Social, emotional, or personal intelligence involves "being aware of the motives and feelings of other people and oneself; knowing what to do to fit into different social situations; knowing what makes other people tick" (Peterson & Seligman, 2004, p. 29). Individuals who exhibit this strength are highly capable of perceiving and understanding emotions in their relationships (Peterson & Seligman, 2004). While treated as a unified trait, this strength is made up of three overlapping components. The first component is emotional intelligence, or the ability to use emotional information in one's thinking (Peterson & Seligman, 2004). Emotional intelligence has been shown to correlate with psychological and subjective well-being, social competence, and relationship quality (Brackett & Mayer, 2003; Brackett, Mayer, & Warner, 2004; Brackett, Rivers, Shiffman, Lerner, & Salovey, 2006; Brackett, Warner, & Brosco, 2005; Lopes, Brackett, Nezlek, Schultz, Sellin, & Salovey, 2004). Personal intelligence describes the ability to accurately understand and assess oneself and is related to better

performance (Peterson & Seligman, 2004). Lastly, social intelligence involves one's understanding and relating to others (Peterson & Seligman, 2004). It is important to consider a person's abilities to experience and utilize emotions, and their ability to relate to others, because this ability may influence their perception and reactions to others.

Justice

Justice is a civic virtue that relates to community life (Peterson & Seligman, 2004). These social strengths include Citizenship, Fairness, and Leadership (Peterson & Seligman, 2004). Fairness is discussed here.

Fairness. Fairness involves "treating all people the same according to notions of fairness and justice; *not* letting personal feelings bias decisions about others; giving everyone a fair chance" (Peterson & Seligman, 2004, p. 30). This strength may be understood as the outcome of moral judgment, or the ability to determine what is morally right and wrong (Peterson & Seligman, 2004). Fairness has been found to be related to moral identity, perspective taking, self-reflection, and problem solving (Peterson & Seligman, 2004). Fairness is also related to greater prosocial and less antisocial behaviors and attitudes (Blasi, 1980).

Temperance

Temperance is a virtue that is illustrated by lack of excess (Peterson & Seligman, 2004). Strengths related to temperance protect against hatred (i.e., protected by Forgiveness and Mercy), arrogance (i.e., Humility and Modesty), favoring short-term gains despite long-term costs (i.e., Prudence), and emotional extremes (i.e., Self-Regulation; Peterson & Seligman, 2004). Forgiveness and Mercy is discussed here.

Forgiveness and Mercy. Forgiveness and Mercy involves "forgiving those who have done wrong; accepting the shortcomings of others; giving people a second chance;

not being vengeful" (Peterson & Seligman, 2004, p. 30). Individuals who exhibit forgiveness tend to be more positive and less negative toward their transgressors (Peterson & Seligman, 2004). Forgiveness has been found to be negatively associated with social dysfunction, anger, and depression (Berry, Worthington, Parrott, O'Connor, & Wade, 2001; Maltby, Macaskill, & Day, 2001; Rye et al., 2001). Furthermore, forgiveness is positively associated with empathy, well-being and social desirability (Fehr, Gelfand, & Nag, 2010; Peterson & Seligman, 2004; Rye et al., 2001).

Transcendence

Transcendence is a virtue that involves making connections to a larger meaning and universe (Peterson & Seligman, 2004). This virtue includes strengths such as Appreciation of Beauty, Gratitude, Hope, Humor, and Spirituality (Peterson & Seligman, 2004). Hope is discussed here.

Hope. Hope, optimism, or future-mindedness involves "expecting the best in the future and working to achieve it; believing that a good future is something that can be brought about" (Peterson & Seligman, 2004, p. 30). Hope, thus, involves cognitive, emotional, and motivational perceptions of a positive future (Peterson & Seligman, 2004). This strength predicts many desirable outcomes such as achievement and psychological adjustment (Arnau, Rosen, Finch, Rhudy, & Fortunate, 2007; Snyder, 2002).

Character Strengths and Stigmatization of Mental Illness

Character strengths are similar to personality traits in that they are relatively stable and reflect individual differences (Peterson & Seligman, 2004). Thus, the study of character strengths may be a beneficial perspective on the "personality approach" for understanding differences in prejudicial attitudes (Ekehammar & Akrami, 2003). In

addition, a number of character strengths are thought to not only be related to cultivation of happiness and well-being in the individual displaying such traits but are also thought to enhance relationships and even improve well-being in others (e.g., kindness, fairness, forgiveness). Furthermore, just as the field of positive psychology seeks to improve quality of life (Seligman & Csikszentmihalyi, 2000), the study of character strengths may enlighten traits that may be fostered to promote a less prejudicial society.

No research has been published relating character strengths to stigma, prejudice, or discrimination. A relationship is hypothesized to exist because character strengths have been repeatedly associated with prosocial attitudes and behavior (see Peterson & Seligman, 2004 for review). The nine character strengths being assessed in this study were chosen as ones possibly related to prejudice and the stigmatization of mental illness based on their construct definitions. Specifically, Open-Mindedness is defined as weighing evidence fairly despite biases; Perspective involves promoting others' well-being; Bravery has been related to altruism; Integrity is linked to positive interpersonal outcomes; Kindness is related to empathy, sympathy, and volunteerism; Social Intelligence is defined as social competence; Fairness involves making unbiased decisions about others and has been related to prosocial behaviors and attitudes; Forgiveness and Mercy involves accepting others' shortcomings and having empathy for others, and; Hope is related to adjustment, the opposite of the maladjustment hypothesized to be characteristic of prejudice (Hodson et al., 2009; Peterson & Seligman, 2004).

Empathy

Empathy has been described both cognitively and affectively (Duan & Hill, 1996). Cognitive empathy involves taking the perspective of another while affective

empathy involves vicariously experiencing another's distress (Gladstein, 1983). Either way, empathy is associated with altruistic responses even when stereotypes are endorsed and may increase prosocial behavior and evaluations of a stigmatized group (Batson et al., 1997; Coke, Batson, & McDavis, 1978; Eisenberg & Miller, 1987; Stephan & Finlay, 1999; Vescio, Sechrist, & Paolucci, 2003). Lacking empathy is associated with aggression, antisocial behaviors, and negative attitudes (Stephan & Finlay, 1999). Empathy not only improves attitudes toward a stigmatized group; it also encourages taking action to improve the welfare of that group and improving overall intergroup relations (Batson, Chang, Orr, & Rowland, 2002; Stephan & Finlay, 1999).

Empathy and Stigmatization of Mental Illness

Empathy is associated with more positive and prosocial attitudes toward a prejudiced group (Batson et al., 1997, 2002; Stephan & Finlay, 1999; Vescio et al., 2003), even when stereotypes remain endorsed (Batson et al., 1997). Empathy is also associated with more helping and prosocial behaviors (Batson et al., 2002; Coke et al., 1978; Eisenberg & Miller, 1987; Stephan & Finlay, 1999) while a lack of empathy is related to antisocial behaviors (Stephan & Finlay, 1999). Specific to the stigmatization of mental illness, Phelan and Basow (2007) found empathy to be related to increased social tolerance.

Several ideas have been suggested to explain the link between empathy and improved attitudes and behaviors. These include that empathy allows for the recognition of another person's distress (Coke et al., 1978; Phelan & Basow, 2007) and arouses concern about other people (Phelan & Basow, 2007). Empathy may allow one's beliefs about an outgroup to overlap with one's self-concept and lead to a reduction of the "ultimate attribution error," or the tendency to attribute an outgroup's negative outcomes

internally and their positive outcomes externally while attributing one's own negative outcomes externally and positive outcomes internally (Vescio et al., 2003). Helping may be a result of attempts to reduce another person's distress or to reduce one's own arousal in response to that person's distress (Coke et al., 1978). Empathy may also lead to the recognition of another person's needs which may lead to helping (Coke et al., 1978).

Although the link between empathy and positive attitudes and behaviors has been well established, the relationship may be less than straightforward as some studies show no relationship between empathy and prosocial outcomes (Gladstein, 1983; Underwood & Moore, 1982).

Familiarity with Mental Illness

“Familiarity” describes an individual's knowledge of and/or experience with a phenomenon (e.g., Corrigan et al., 2001, 2003).

Familiarity and the Stigmatization of Mental Illness

Allport's (1954) Contact Hypothesis provides the foundation for Intergroup Contact Theory (Pettigrew, 1998). This theory suggests that familiarity influences attitudes and responses (Corrigan et al., 2003). According to Intergroup Contact Theory, contact increases knowledge about the outgroup, reduces anxiety associated with intergroup contact, and facilitates empathy toward the outgroup (Pettigrew & Tropp, 2008; Pettigrew, Tropp, Wagner, & Christ 2011). Thus, having more contact with an outgroup may foster prosocial attitudes and behaviors.

Familiarity has been repeatedly shown to have a negative association with prejudicial attitudes (e.g., Anagnostopoulos & Hantzi, 2011; Corrigan et al., 2001, 2003; Pettigrew & Tropp, 2006; Phelan & Basow, 2007). Specific to the stigmatization of mental illness, familiarity with mental illness has been shown to have a negative

association with social distance and perceived dangerousness of people with mental illness, and positively associated with non-prejudicial attitudes such as the belief that people with mental illness need social support and quality care (Anagnostopoulus & Hantzi, 2011; Brown, 2012; Corrigan et al., 2001; 2003; Phelan & Basow, 2007). However, some studies suggest these relationships may be weaker than previously proposed (Brown, 2012; Phelan & Basow, 2007).

Hypotheses and Rationale

The stigmatization of mental illness is a known problem that has several negative outcomes. Less is known, however, regarding who is most likely to hold these harmful views. By assessing individual characteristics such as personality and character strengths, the current study aims to determine which combinations of personality traits and character strengths are both positively and negatively associated with the stigmatization of people with mental illness.

The current study seeks to expand upon existing literature regarding the stigmatization of mental illness. First, this study will include known predictors of stigma (i.e., Big Five personality traits, empathy, and familiarity with mental illness) in order to further define the relationship between these variables and the stigmatization of mental illness. It was hypothesized that less stigmatizing views may be related to Extraversion because it involves affection and sociability, Agreeableness because people high in Agreeableness are described as being oriented toward and concerned with others as well as warm and altruistic, Conscientiousness because it is represented as being moralistic and ethical, and Openness to Experience because it is described as being perceptive and in tune with one's feelings and experiences as well as a desire to consider other values and belief systems. On the other hand, Neuroticism was hypothesized to be associated

with more stigmatizing attitudes primarily because of its facets of the propensity to experience the negative emotions of mistrust and hostility. These hypotheses are also based on previous findings. Furthermore, it is hypothesized that empathy will be associated with less stigmatizing attitudes. This is based on previous findings and empathy's association with more positive intergroup attitudes. Lastly, familiarity with mental illness will also be associated with less stigmatizing attitudes. This is based on previous findings and the Intergroup Contact Theory's suggestion that familiarity is effective in reducing prejudice.

Second, the current study examined additional variables (i.e., the Dark Triad personality traits and character strengths). Only one study found has evaluated the Dark Triad traits in relation to prejudice (i.e., Hodson et al., 2009). This study will add to the literature and be the first to evaluate the association between the Dark Triad traits and stigmatization specific to people with mental illness. Based on previous literature relating the Dark Triad traits to prejudice and their association with antisocial attitudes and behaviors, it was hypothesized that Narcissism, Psychopathy, and Machiavellianism would be associated with more stigmatizing attitudes. No studies have examined how character strengths are related to stigmatizing attitudes. This study was thus the first to evaluate the relationship between character strengths and the stigmatization of mental illness. It was hypothesized that all of the character strengths being assessed (i.e., Open-Mindedness, Perspective, Bravery, Integrity, Kindness, Social Intelligence, Fairness, Forgiveness and Mercy, and Hope) would be associated with less stigmatizing attitudes. This is based on character strengths being associated with prosocial attitudes and behaviors.

Third, the current study was the first to study these relationships at the multivariate level. Specifically, the current study utilized multivariate analyses to examine (1) how various combinations of personality traits and character strengths predict the stigmatization of mental illness and (2) whether personality traits, character strengths, and empathy predict the stigmatization of mental illness above and beyond familiarity with mental illness.

Lastly, the current study explored differences in stigmatization based on disorder type by examining reactions to targets described as having a mood disorder (i.e., Major Depressive Disorder), a personality disorder (i.e., Borderline Personality Disorder), Schizophrenia, and a chronic medical illness (i.e., Leukemia). Major Depressive Disorder was chosen because despite its relatively high prevalence and familiarity, it continues to elicit stigmatizing attitudes (e.g., Feldman & Crandall, 2007). Borderline Personality Disorder was chosen as a less familiar, but pervasive disorder with characteristics influencing interpersonal relationships. It has also been suggested that the stigma associated with Borderline Personality Disorder is one of the most severe (Aviran, Brodsky, & Stanley, 2006; Feldman & Crandall, 2007). Schizophrenia was chosen because it is a commonly used disorder in studies of stigmatization and a replication of previous findings is warranted. Despite its low prevalence rate, Schizophrenia has been repeatedly portrayed in the media (e.g., in books such as *One Flew Over the Cuckoo's Nest* and in movies such as *A Beautiful Mind*). Attitudes may thus be based primarily on media portrayals of the disorder rather than on personal familiarity. Lastly, Leukemia was chosen to be a condition which is not expected to elicit stigmatizing views, such as assumptions of personal responsibility for the illness. As such, the Leukemia target is included for comparison purposes. Based on previous findings and the higher prevalence

rates and media coverage (and thus more familiarity), it is expected that the Major Depressive Disorder vignette will elicit the least stigmatizing attitudes when compared to Schizophrenia and Borderline Personality Disorder. Furthermore, it is hypothesized that Schizophrenia will be associated with less stigmatizing attitudes than Borderline Personality Disorder because of its higher familiarity via media coverage. Thus, Borderline Personality Disorder is hypothesized to be related to the most stigmatizing attitudes because of its possible lack of familiarity.

CHAPTER II

METHOD

Participants

Primary Study

Prior to conducting the current study, a power analysis was performed to determine an appropriate number of participants. This power analysis used the F test because linear multiple regressions were the primary analyses conducted. Power of .80 and alpha .05 was specified. Because different sets of predictors were used, a power analysis was conducted using nine predictors because this was the analysis with the largest predictor set conducted for the current study, and thus was the most conservative power estimate. Although previous literature suggests small effect sizes, limited resources prevented this study from having enough participants to detect such small effects. For example, approximately 800 participants would be needed to detect a small effect size of .02 given nine predictors. Given the feasibility of obtaining 200 to 300 participants, a power analysis was then conducted to determine the effect size detectable if these numbers were obtained. Results show that while the suggested guideline for small effect sizes may not be obtained, relatively small effect sizes (i.e., .05-.08) may still be detected with 200 to 300 participants even with the most conservative measure (i.e., nine predictors).

A convenience sample of 301 undergraduate students from the University of Southern Mississippi were recruited via the Psychology Department's online subject pool, SONA, to complete this study online via a secure online server, Qualtrics. Participants were 18 years of age or older and who participated in partial fulfillment of a course requirement or for extra credit in psychology courses. Forty-two participants (14.0%)

were excluded from analyses for failure to meet quality assurance requirements (i.e., answering appropriately to at least two of the three quality assurance items). Of the 259 final participants (see Table 1 for demographics), a majority were female (88.0%) and White (59.8%) or African American (34.7%). Ages ranged from 18- to 58-years-old (M = 21.33, SD = 5.94), and participants ranged from being in college one to five or more years (M = 2.39, SD = 1.32).

Table 1

Demographics Characteristics for Primary Sample (n = 259)

Characteristic	n	%
Gender		
Female	228	88.0
Male	31	12.0
Race/Ethnicity		
White	155	59.8
African American	90	34.7
Asian/Pacific Islander	5	1.9
Hispanic/Latino	4	1.5
Other	3	1.2
Native American/Eskimo/Aleut	2	.8
Year in College		
First	94	36.3
Second	50	19.3
Third	56	21.6
Fourth	38	14.7
Fifth or later	21	8.1

Pilot Study

A total of 21 clinical psychology graduate students from the University of Southern Mississippi completed the pilot study to determine if the vignette targets described the illnesses they were intended to (see Table 2 for demographics). A majority of participants were female (81.0%) and ranged from being in the program 1 to 5 years (M = 2.86; SD = 1.68).

Table 2

Demographic Characteristics for Pilot Sample (n = 21)

Characteristic	n	%
Gender		
Female	17	81.0
Male	4	19.0
Year in USM's Clinical Psychology Program		
First	6	28.6
Second	4	19.0
Third	4	19.0
Fourth	3	14.3
Fifth	2	9.5
Other	2	9.5

Note. USM = University of Southern Mississippi.

Procedure

The current study was approved by the Institutional Review Board of The University of Southern Mississippi (see Appendix A for a copy of the IRB approval letter). The study was presented online via the Qualtrics web survey platform. After providing informed consent, participants completed self-report measures assessing demographic information, Big Five personality traits (Big Five Inventory); Dark Triad

personality traits (Dark Triad – Short Form); empathy (Interpersonal Reactivity Index); character strengths (Values in Action Inventory of Strengths), and familiarity with mental illness (Level of Contact Report). Participants were then presented with four vignettes in a counterbalanced order each presenting a description of a male or female target (sex matched that of participants) with a mental or medical illness. Included within these vignettes were a brief description of some of the target's behaviors and symptoms that varied depending on their illness (i.e., Major Depressive Disorder, Borderline Personality Disorder, Schizophrenia, or leukemia), but no diagnostic labels were mentioned. After reading each vignette, participants completed three measures in reference to their opinions of the target. These measures all tapped into different aspects of stigma and included measures of their beliefs about the dangerousness of the target (Dangerousness Scale – Individual), their desired social distance from the target (Social Desirability Rating Scale), and their beliefs that the target described is personally responsible for his or her illness (Attribution Questionnaire). At the end of the study, participants were thanked for their time and informed that credits for their participation would be granted on SONA within the next two to three business days.

Vignettes

Each participant read four vignettes. Each vignette described a target with either a mood disorder (i.e., Major Depressive Disorder), a personality disorder (i.e., Borderline Personality Disorder), a psychotic disorder (i.e., Schizophrenia), or a medical disorder control (i.e., Leukemia). Leukemia was chosen as the control due to its chronicity and minimal likelihood of individuals ascribing personal responsibility for the disease or other stigmatizing views to this target.

Vignettes included identifying information for a fictional target (i.e., name, sex, age) and observable traits and behaviors that may be indicative of the illness being presented (i.e., Major Depressive Disorder, Borderline Personality Disorder, Schizophrenia, or Leukemia) according to the *DSM-5* (APA, 2013) or symptoms of Leukemia (National Cancer Institute, 2013). See Appendix B for vignettes used in the current study.

Participant Characteristics Measures

Values in Action Inventory of Strengths, Adult Survey-120. The Values in Action Inventory of Strengths (VIA-IS; Peterson & Park, 2009; Peterson & Seligman, 2004) is a self-report measure of the 24 character strengths identified in the Values in Action Classification of Strengths (Peterson & Seligman, 2004). A brief version of this measure (VIA-120; Peterson, Park, & Seligman, 2005) was created using the five items with the highest item-scale correlations from each set of the original ten items per scale. This brief version thus has 120 questions with 5 items per character strength. The VIA-120 is highly correlated with the original measure ($r = .93$) and has demonstrated similar validity to that of the long form (with Activities Questions, $r = .50$ and .55 for VIA-120 and long form, respectively; with Flourishing Scale, $r = .39$ and .43 for VIA-120 and long form, respectively; Values in Action Institute on Character, 2013). Scale scores from the VIA-120 also show good internal consistency (alphas range from .69 to .91 with an average of .79; Values in Action Institute on Character, 2013). Only the Open-Mindedness, Perspective, Bravery, Integrity, Kindness, Social Intelligence, Fairness, Forgiveness and Mercy, and Hope scales were used in the current study. Due to the proprietary nature of the instrument and scoring keys, scoring of the measure was done by the VIA Institute on Character, using a de-identified data file with subject numbers in order to match score

with the rest of the database. Given that the researcher did not have access to the scoring key, alphas from the current study data could not be computed.

Big Five Inventory. The Big Five Inventory (BFI; John, Donahue, & Kentle, 1991) assesses the Big Five factors of personality (i.e., Extraversion, Agreeableness, Conscientiousness, Neuroticism, and Openness to Experience). The BFI was designed as a brief and psychometrically sound measure of the Five-Factor Model (John & Srivastava, 1999) and is commonly used by social-personality psychologists (Miller, Gaughan, Maples, & Price, 2011). Participants rate their agreement on the degree to which each of 44 items are descriptive of themselves using a 5-point Likert scale ranging from 1 (disagree strongly) to 5 (agree strongly). Each item consists of short phrases based on trait adjectives that are known to be related to prototypical markers of each personality dimension (cf. John & Srivastava, 1999). BFI scores have shown a clear factor structure (John & Srivastava, 1999; Worrell & Cross, 2004), good reliability (alphas range from .79 to .88 with an average of .83), good convergent validity with other personality measures (ranging from .73 to .81), and good three-month test-retest reliability (ranging from .80 to .90; John & Srivastava, 1999). Furthermore, BFI scores have shown similar reliability in administration of the BFI over the Internet with standard administration of the BFI (alphas range from .79 to .86; Srivastava, John, Gosling, & Potter, 2003). The current study used item response averages computed for each subscale. Alphas from the current study indicated good internal consistency reliability, ranging from .73 for Openness to .80 for Extraversion.

Dark Triad – Short Form. The Dark Triad Short Form (SD3; Jones & Paulhus, 2014) yields scores for the personality traits of Machiavellianism, Narcissism, and Psychopathy. Participants rate their agreement on 27 items using a 5-point scale. SD3

scores have shown good internal consistency reliability (α= .77 for Machiavellianism, .80 for Psychopathy, and .71 for Narcissism; Jones & Paulhus, 2014) and good external reliability with informant ratings (*r*s = .62 for Machiavellianism, .86 for Psychopathy, and .67 for Narcissism; Jones & Paulhus, 2014). SD3 scores have also shown good convergent validity with another Dark Triad measure (i.e., Dirty Dozen; *r*s = .54-.65; Maples et al., 2013) and with established measures for Machiavellianism ($r = .68$ for Christie-Geis Machiavellianism, Mach-IV; Jones & Paulhus, 2014), Psychopathy ($r = .78$ for Self-Report Psychopathy, SRP-III; Jones & Paulhus, 2014), and Narcissism ($r = .70$ for Narcissistic Personality Inventory, NPI; Jones & Paulhus, 2014). Furthermore, the SD3 has shown good facet representation with strong correlations with all facets on the established measure that corresponds with each subtest. For example, the SD3 Machiavellianism subscale showed representation of both cynical and manipulative subscales for the Mach-IV ($r = .55$ and .52, respectively; Jones & Paulhus, 2014), the SD3 Psychopathy scale showed representation of manipulation, callous affect, erratic lifestyle, and antisocial behavior subscales for the SRP-III (*r*s = .67, .63, .59, and .57, respectively; Jones & Paulhus, 2014), and the SD3 Narcissism scale showed representation of both the exploitative/entitlement and leadership/authority affect subscales for the NPI ($r = .60$ and .56, respectively; Jones & Paulhus, 2014). The current study used item response averages computed for each subscale. Alphas from the current study indicated good internal consistency reliability, ranging from .640 for Narcissism to .821 for Psychopathy.

Interpersonal Reactivity Index. The Interpersonal Reactivity Index (IRI; Davis, 1980) measures four facets of empathy to encompass cognitive (i.e., Perspective-Taking and Personal Distress) and emotional (i.e., Fantasy and Empathic Concern) components.

As described by Davis (1980), the Perspective-Taking scale assesses the tendency to take another person's perspective and see things from their point of view. The Fantasy scale assesses the tendency for an individual to identify with fictional characters. The Empathic Concern scale assesses the individual's feelings of warmth, compassion, and concern for another person. The Personal Distress scale assesses the individual's feelings of anxiety and discomfort when viewing another person in suffering. Participants rate their agreement on 28 items using a 5-point scale. IRI subscale scores have shown good reliability (αs = .68-.79; Davis, 1980) and three-month test-retest reliability (*r*s = .61-.81; Davis, 1980). Furthermore, the Perspective-Taking and Personal Distress scale scores have shown good convergent validity with a cognitive measure of empathy (i.e., Hogan Empathy Scale; $r = .40$ and -.33, respectively; Davis, 1983), and the Fantasy and the Empathic Concern scale scores have shown good convergent validity with an emotional measure of empathy (i.e., Mehrabian & Epstein measure; $r = .52$ and .60, respectively; Davis, 1983). The Empathic Concern, Fantasy, and Perspective Taking subscales have been shown to load onto a “General Empathy” factor while Personal Distress loaded onto a separate factor (Pulos, Elison, & Lennon, 2004). The current study used an Exploratory Factor Analysis to assess the factor structure and results suggest a “General Empathy” factor in which all subscales (i.e., Empathic Concern, Fantasy, Perspective Taking, and Personal Distress) load onto a single factor. Alphas indicated good internal consistency reliability ($\alpha = .778$).

Level of Contact Report. The Level of Contact Report (LCR; Holmes et al., 1999) is used to assess familiarity with mental illness. Many studies just ask “Do you know someone with a mental illness?” (e.g., Penn et al., 1994), but this categorical method lacks power (Holmes et al., 1999). The LCR was created in response to this

limitation. The LCR contains a list of 12 situations developed from other scales (see Holmes et al., 1999). Participants are asked to select all situations that they have experienced from the list. Each situation has a rank ranging from lowest intimacy (i.e., "I have never observed a person that I was aware had a mental illness") to highest intimacy (i.e., "I have a mental illness"). The overall score is equal to the highest ranked situation endorsed. Rank orders were determined by three experts in the field and showed good inter-rater reliability (r = .83; Holmes et al., 1999). The current study computed an overall score equal to the highest ranked situation endorsed.

Stigmatizing Perceptions of Vignette Targets

Participants completed the following measures specifically in reference to their perceptions of the persons depicted in each of the three vignettes.

Dangerousness Scale–Individual. The Dangerousness Scale–Individual (Penn et al., 1999) is used to measure the degree of belief that an individual is dangerous to others. Participants rate their level of agreement with 4 items on a 7-point scale. A score will be computed from an average of the items. The Dangerousness Scale–Individual has shown good internal consistency (α = .77) and modest correlation with another measure of dangerousness (i.e., Dangerousness Scale—General; r = .69; Penn et al., 1999). The current study used the average of scale items. Alphas from the current study indicated good internal consistency reliability, ranging from .793 in reference to Borderline Personality Disorder to .852 in reference to Leukemia.

Social Desirability Rating Scale. The Social Desirability Rating Scale (Canu et al., 2008) is used to evaluate perceptions of the social desirability of a target. Participants rate the likelihood of engaging in 5 specific activities with the target on a 6-point scale. An overall score was computed by averaging item scores. The Social Desirability Rating

Scale scores have shown good internal consistency (α = .83) and two-week test-retest reliability (r = .78; Canu et al., 2008). The current study used the average of scale items. Alphas from the current study indicated good internal consistency reliability, ranging from .900 in reference to Major Depressive Disorder to .915 in reference to Borderline Personality Disorder.

Attribution Questionnaire. The Attribution Questionnaire (AQ; Corrigan et al., 2003) is used to assess familiarity with mental illness, personal responsibility beliefs, pity, anger, fear, helping, and attitudes toward coercion-segregation. The current study only used the subscale designed to assess perceptions of personal responsibility. Participants rated their agreement on 3 items related to perceived personal responsibility for the illness possessed by the target on a 9-point scale. A score was derived from the average rating of the three items. This Personal Responsibility subscale has shown fair internal consistency (α = .60-.70; Brown, 2008; Corrigan et al., 2003), good one-week test-retest reliability (r = .80; Brown, 2008), and good discriminant validity from other measures (i.e., r = .08 with Social Distance Scale, r = -.20 with Dangerousness Scale, and r = .05 Affect Scale; Brown, 2008). The current study used the average of scale items. Alphas from the current study indicated good internal consistency reliability, ranging from .773 in reference to Leukemia to .866 in reference to Major Depressive Disorder.

Statistical Analyses

Only cases in which at least two of the three quality assurance items were answered appropriately were included for analysis. Quality assurance items appeared throughout the survey (i.e., within the VIA-120, BFI, and IRI) and were used to ensure participants read items and responded appropriately. Specifically, items included for quality assurance purposes were the following: “Please choose 'very much unlike me' for

this item," "I see myself as someone who is a student," and "I have never seen a building." These items were chosen because they have known correct answers (e.g., all participants had to be students in order to participate in the study).

Missing data analyses were conducted by counting the number of missing items per each subject per each scale. Participants with more than 20% of responses missing for a scale were excluded for the given scale. When less than 20% of responses were missing for a given scale, intra-individual means for that scale were substituted for the missing values. Descriptive statistics for each scale were then computed and skewness and kurtosis were examined to assess normality and no violations were detected. Zero-order correlations among all independent and dependent variables were computed. Correlations between all independent and dependent variables are presented in Appendix C.

Are the vignettes descriptive of their respective illnesses?

Prior to the study, a pilot study was conducted to assess if the target descriptions accurately described the illnesses which they were intended to portray. Graduate students enrolled in the University of Southern Mississippi's Clinical Psychology program were recruited as participants of the pilot study. Participants read each vignette and then provided their conclusion regarding what diagnosis they thought was most appropriate for the target. Accuracy of descriptions was computed as the percentage of participants "diagnosing" the target with the intended illness.

Are participant characteristics predictive of stigmatization of mental illness? Do these relationships differ based on type of disorder?

Multiple regression analyses were used to determine the degree to which personality traits and character strengths, as a group, predict stigmatizing views of the vignette target presenting with mental illness in the vignettes. Separate regressions were

conducted for three groupings of conceptually similar independent variables (Big Five traits, Dark Triad traits, and character strengths) predicting the "Stigma" latent variable. Zero-order correlations were used to analyze the relationships between empathy and familiarity with mental illness, and the "Stigma" latent variable.

Familiarity with mental illness was then used as a control variable in hierarchical regression analyses to assess if Big Five traits, Dark Triad traits, character strengths, and empathy predict measures of stigmatization above and beyond familiarity with mental illness.

Do levels of stigmatization vary depending on type of disorder?

A repeated-measures ANOVA was used to assess if overall stigmatizing views varied based on vignette (i.e., mood disorder vs. personality disorder vs. psychotic disorder vs. medical disorder control). An ANOVA was conducted with the stigma variables as the dependent variables and the type of disorder as the independent variable. Comparisons were made among all four vignette types.

A repeated measures MANOVA was then used to assess if specific types of stigmatizing views varied based on vignette. A MANOVA was conducted with the stigma variables (i.e., dangerousness, social desirability, and responsibility) as the dependent variables and the type of disorder as the independent variable. Comparisons were made among all four vignette types. These analyses were done in order to determine if differences in stigmatization existed according to the different disorders portrayed by targets.

Data elicited from each vignette type were also separated and analyzed as before (i.e., multiple regressions, correlations) to assess if different effect sizes or patterns of

individual characteristics related to stigmatization differed according to vignette condition.

CHAPTER III

RESULTS

Preliminary Findings

Pilot Study Results

All vignettes had adequate diagnostic accuracy (Table 3). Specifically, for the vignette meant to describe a target with Major Depressive Disorder, 100% (n = 13) of participants "diagnosed" the target with Major Depressive Disorder. For the vignette meant to describe a target with Borderline Personality Disorder, 92.3% (n = 13) of participants diagnosed the target with Borderline Personality Disorder. For the vignette meant to describe a target with Schizophrenia, 42.9% (n = 7) of participants diagnosed the target with Schizophrenia. Due to this lack of accuracy, changes were made to the vignette to more specifically state the presence of auditory hallucinations and odd behaviors. With this change, accurate diagnosis increased to 92.3% (n = 13). Lastly, for the vignette meant to describe a target with Leukemia, 92.3% (n = 13) of participants diagnosed the target with a medical condition. Thus all vignettes were deemed to adequately describe their intended condition and were used in the primary study.

Table 3

Accuracy of Vignette Descriptions

Vignette/Response	n	%
Major Depressive Disorder Vignette		
Major Depressive Disorder	13	100.0
Other	0	.0

Table 3 (continued).

Vignette/Response	n	%
Borderline Personality Disorder Vignette		
Borderline Personality Disorder	12	92.3
Other	1	7.7
Schizophrenia Vignette (Original)		
Schizophrenia	3	42.9
Other	4	57.1
Schizophrenia Vignette (Revised)		
Schizophrenia	12	92.3
Other	1	7.7
Leukemia Vignette		
Medical condition	12	92.3
Other	1	7.7

Exploration of Latent "Stigma" Variables

Principal components analyses (PCA) were conducted to determine if the three variables assessing stigma (i.e., Dangerousness, Personal Responsibility, and Social Distance) loaded into a single component, thus indicating the appropriateness of combining these three scores into a single stigma variable. Separate PCA's were conducted for the data derived from responses to each of the target conditions (Table 4).

Table 4

Factor Loadings from Principal Components Analyses: Communalities, Eigenvalues, and Percentages of Variance for Stigmatization of Vignettes

Item	Factor Loading 1	Communality
Major Depressive Disorder Stigma		
Dangerousness	.677	.459
Responsibility	.666	.443
Social distance	.644	.414
Eigenvalue	1.316	
% of variance	43.879	
Borderline Personality Disorder Stigma		
Dangerousness	.770	.592
Responsibility	.664	.440
Social distance	.720	.518
Eigenvalue	1.551	
% of variance	51.703	
Schizophrenia Stigma		
Dangerousness	.794	.630
Responsibility	.207	.043
Social distance	.795	.632
Eigenvalue	1.305	
% of variance	43.499	
Leukemia Stigma		
Dangerousness	.724	.524
Responsibility	.736	.541
Social distance	.565	.319
Eigenvalue	1.385	
% of variance	46.156	

For the PCA of stigma scores derived in reference to the target with Major Depressive Disorder, the three eigenvalues were 1.316, .856, and .828. In addition, the scree plot showed a clear elbow after the first factor. Thus, it was determined that the data are best represented by one factor, which explained 43.9% of the variance. The factor loadings and communalities are presented in Table 4. As seen in the table, all three stigma variables made strong contributions to the factor, “Stigma Towards Major Depressive Disorder.” Stigma Towards Major Depressive Disorder scores were then computed by summing scores for perceived dangerousness, personal responsibility, and social distance of the target with Major Depressive Disorder. To assure the validity of summed scores, correlations were computed between summed scores and factor scores. The high correlation between Major Depressive Disorder Stigma's summed score and factor score ($r = .972$, $p < .001$) suggests validity of using the summed score.

For the PCA of stigma scores derived in reference to the target with Borderline Personality Disorder, the three eigenvalues were 1.551, .795, and .654. In addition, the scree plot showed a clear elbow after the first factor. Thus, it was determined that the data are best represented by one factor, which explained 51.7% of the variance. As seen in Table 4, all three stigma variables made strong contributions to the factor, “Stigma Towards Borderline Personality Disorder.” Stigma Towards Borderline Personality Disorder scores were computed by summing scores for perceived dangerousness, personal responsibility, and social distance of the target with Borderline Personality Disorder. The high correlation between Borderline Personality Disorder Stigma's summed score and factor score ($r = .968$, $p < .001$) suggests validity of using the summed score.

For the PCA of stigma scores derived in reference to the target with Schizophrenia, the three eigenvalues were 1.305, .990, and .705. In addition, the scree plot showed a clear elbow after the first factor. Thus, it was determined that the data are best represented by one factor, which explained 43.5% of the variance. As shown in Table 4, all three stigma variables made strong contributions to the factor, “Stigma Towards Schizophrenia” although personal responsibility only weakly loaded. Stigma Towards Schizophrenia scores were computed by summing scores for perceived dangerousness, personal responsibility, and social distance of the target with Schizophrenia. The high correlation between Schizophrenia Stigma's summed score and factor score ($r = .816$, $p < .001$) suggests validity of using the summed score.

Lastly, for the PCA of stigma scores derived in reference to the target with Leukemia, the three eigenvalues were 1.385, .885, and .730. In addition, the scree plot showed a clear elbow after the first factor. Thus, it was determined that the data are best represented by one factor, which explained 46.2% of the variance. As shown in Table 4, all three stigma variables made strong contributions to the factor, “Stigma Towards Leukemia”. Stigma Towards Leukemia scores were computed by summing scores for perceived dangerousness, personal responsibility, and social distance of the target with Leukemia. The high correlation between Leukemia Stigma's summed score and factor score ($r = .977$, $p < .001$) suggests validity of using the summed score.

A PCA was conducted to determine if the three disorder-specific stigma variables related to mental illness (i.e., Stigma Towards Major Depressive Disorder, Stigma Towards Borderline Personality Disorder, and Stigma Towards Schizophrenia) loaded into a higher order factor. For the PCA of stigma scores in reference to the three mental

illnesses, the three eigenvalues were 1.904, .611, and .485. In addition, the scree plot showed a clear elbow after the first factor. Thus, it was determined that the data are best represented by one factor, which explained 63.5% of the variance. As seen in Table 5, all three stigma variables made strong contributions to the factor, "Stigma Towards Mental Illness" (Table 5). Stigma Towards Mental Illness scores were computed by averaging scores for Stigma Towards Major Depressive Disorder, Borderline Personality Disorder, and Schizophrenia. The high correlation between Stigma Toward Mental Illness's averaged score and factor score ($r = .999$, $p < .001$) suggests validity of using the mean score.

Table 5

Factor Loadings from Principal Components Analysis: Communalities, Eigenvalues, and Percentages of Variance for Stigmatization of Mental Illness

	Factor Loading	
Item	1	Communality
Stigmatization of Mental Illness		
MDD Stigma	.783	.613
BPD Stigma	.775	.601
Schizophrenia Stigma	.831	.691
Eigenvalue	1.904	
% of variance	63.482	

Note. MDD = Major Depressive Disorder; BPD = Borderline Personality Disorder.

Individual Characteristics and the Stigmatization of Mental Illness

Familiarity with Mental Illness and the Stigmatization of Mental Illness

Familiarity with mental illness was not found to be significantly associated with the stigmatization of mental illness ($r = -.057$, $p = .371$, Table 6). Familiarity was then

used as a control variable in hierarchical regressions, but because it was not significantly related to any variables of interest, results did not differ with and without the control variable. Therefore, results are presented without using Familiarity as a control.

Empathy and the Stigmatization of Mental Illness

Empathy was found to be significantly related to the stigmatization of mental illness (r = -.165, p = .009, Table 6). Specifically, higher trait empathy was associated with less endorsement of stigmatizing attitudes toward individuals with mental illness.

Table 6

Correlations of Stigmatization of Mental Illness With Individual Characteristics

	r	p
Empathy	-.165	.009
Familiarity	-.057	.371

The Big Five Personality Traits and the Stigmatization of Mental Illness

Using multiple regression analysis, the Big Five personality traits (i.e., Agreeableness, Extraversion, Conscientiousness, Neuroticism, and Openness to Experience) showed no relationship with the stigmatization of mental illness (R^2 = .024, p = .320, Table 7).

Table 7

Regression Analyses Summary for Individual Variables Predicting Stigmatization of Mental Illness

Variable	B	SE B	Beta	t	p
Big Five Personality Traits					
Agreeableness	-.429	.338	-.096	-.127	.205
Extraversion	.309	.212	.095	1.456	.147
Conscientiousness	.314	.328	.073	.957	.340
Neuroticism	-.164	.251	-.046	-.651	.516
Openness to Experience	-.317	.291	-.071	-.109	.276
Dark Triad Personality Traits					
Machiavellianism	.015	.284	.004	.054	.957
Narcissism	.780	.301	.179	2.588	.010
Psychopathy	.318	.298	.076	1.065	.288
Character Strengths					
Open-mindedness	.033	.414	.007	.079	.937
Perspective	.114	.318	.032	.358	.720
Bravery	-.056	.351	-.014	-.160	.873
Integrity	.349	.499	.065	.699	.485
Kindness	-.111	.451	-.024	-.247	.805
Social intelligence	.539	.382	.132	1.408	.160
Fairness	-1.114	.439	-.242	-2.534	.012
Forgiveness and mercy	-.347	.278	-.103	-1.248	.213
Hope	.582	.327	.152	.178	.077

Note. Big Five Personality Traits R^2 = .024 (p = .320). Dark Triad Personality Traits R^2 = .043 (p = .014). Character Strengths R^2 = .083 (p = .013).

The Dark Triad Personality Traits and the Stigmatization of Mental Illness

A multiple regression of Dark Triad personality traits revealed an association with the stigmatization of mental illness (R^2 = .043; *p* = .014, Table 7). Although

Machiavellianism and Psychopathy showed non-significant relationships, Narcissism was found to be positive associated with the stigmatization of mental illness (β = .179, $p = .010$). Thus, higher rankings of Narcissism tend to predict more stigmatizing attitudes regarding individuals with mental illness.

Character Strengths and the Stigmatization of Mental Illness

A multiple regression of selected character strengths showed a relationship with the stigmatization of mental illness ($R^2 = .083$, $p = .013$, Table 7). Only Fairness showed a significant relationship and was found to be negatively associated with the stigmatization of mental illness (β = -.242, $p = .012$) such that individuals who exhibit more Fairness endorse less stigmatizing attitudes toward individuals with mental illness. No other character strengths included in the analysis (i.e., Open-mindedness, Perspective, Bravery, Integrity, Kindness, Social Intelligence, Forgiveness and Mercy, and Hope) were related to the stigmatization of mental illness.

Stigmatization of Different Mental Illnesses

A repeated-measures ANOVA was conducted to assess if stigmatization differed based on diagnosis (i.e., Major Depressive Disorder, Borderline Personality Disorder, Schizophrenia, and Leukemia). There was a significant within-subjects effect for diagnostic condition ($p < .001$, Table 8) and all pair-wise comparisons were significant ($p < .001$). Notably, Leukemia served as an adequate control target as it was associated with minimal stigmatizing attitudes. Major Depressive Disorder was found to be the least stigmatized of the three mental illnesses followed by Schizophrenia and then Borderline Personality Disorder.

Table 8

Means, Standard Deviations, and One-Way Analysis of Variance for the Effects of Vignette Condition on Stigma

Condition	Mean	SE	F	p
Leukemia	5.921	.156	402.880	.000
MDD	9.498	.197		
Schizophrenia	11.048	.197		
BPD	13.205	.219		

Note. MDD = Major Depressive Disorder; BPD = Borderline Personality Disorder.

A repeated-measures MANOVA was then conducted to assess whether the pattern of specific stigmatizing attitudes was the same across diagnoses. The model was significant ($p < .001$, Table 9). Again, Leukemia served as an adequate control target as it was associated with minimal perceived dangerousness, social distance, and personal responsibility. When assessing Dangerousness, all pairwise comparisons were statistically significant ($p < .001$). Of the mental illnesses, Major Depressive Disorder was perceived as the least dangerous, followed by Schizophrenia and then Borderline Personality Disorder. When examining Social Distance, all pairwise comparisons were statistically significant ($p < .001$) except the comparison between Schizophrenia and Borderline Personality Disorder ($p = .141$). Major Depressive Disorder again evoked the least social distance desired followed by Schizophrenia and Borderline Personality Disorder. Lastly, when evaluating Responsibility, all pairwise comparisons were statistically significant ($p \leq .001$). For this variable, Schizophrenia was deemed to be the least personally responsible, followed by Major Depressive Disorder and then Borderline Personality Disorder.

Table 9

Means and Standard Deviations for Stigma Variables as a Function of Disorder

	Dangerousness		Social Distance		Responsibility	
	M	SD	M	SD	M	SD
Leukemia	1.609[a]	.051	2.168[e]	.082	2.143[h]	.094
MDD	2.314[b]	.061	3.035[f]	.096	4.150[i]	.131
Schizophrenia	3.257[c]	.062	4.210[g]	.106	3.582[j]	.134
BPD	3.631[d]	.057	4.440[g]	.108	5.134[k]	.135

Note. MDD = Major Depressive Disorder; BPD = Borderline Personality Disorder. Different superscripts indicate statistically significant mean differences across disorder type.

Stigmatization of Major Depressive Disorder

Analyses were conducted to assess the stigmatization of Major Depressive Disorder. Familiarity with mental illness was not significantly associated with the stigmatization of Major Depressive Disorder (r = -.060, p = .346, Table 10). Despite empathy being associated with stigmatization of mental illness, empathy was not significantly associated with the stigmatization of Major Depressive Disorder (r = -.101, p = .112, Table 10).

Table 10

Correlations of Stigmatization of Major Depressive Disorder With Individual Characteristics

	r	p
Empathy	-.101	.112
Familiarity	-.060	0.35

Using multiple regression, the Big Five personality traits showed no relationship with the stigmatization of Major Depressive Disorder (R^2 = .027, *p* = .237, Table 11). A multiple regression with the Dark Triad personality traits found an association with the stigmatization of Major Depressive Disorder (R^2 = .057; *p* = .003, Table 11). Although Machiavellianism and Psychopathy showed non-significant relationships, Narcissism was found to be positive associated with the stigmatization of Major Depressive Disorder (β = .172, *p* = .013). Lastly, a multiple regression with selected character strengths were found to be related to the stigmatization of Major Depressive Disorder (R^2 = .088, *p* = .008, Table 11). Fairness was the only character strength found to be associated with the stigmatization of Major Depressive Disorder (β = .285, *p* = .003). No other character strengths included were significantly related.

Table 11

Regression Analyses Summary for Individual Variables Predicting Stigmatization of Major Depressive Disorder

Variable	B	SE B	Beta	t	p
Big Five Personality Traits					
Agreeableness	.446	.256	.114	1.744	.082
Extraversion	-.692	.409	-.128	-1.692	.092
Conscientiousness	.220	.395	.042	.555	.579
Neuroticism	-.290	.304	-.067	-.954	.341
Openness to Experience	-.006	.351	-.001	-.017	.986
Dark Triad Personality Traits					
Machiavellianism	.160	.342	.036	.467	.641
Narcissism	.903	.361	.172	2.501	.013
Psychopathy	.562	.359	.110	1.567	.118

Table 11 (continued).

Variable	B	SE B	Beta	t	p
Character Strengths					
Open-mindedness	.040	.499	.007	.079	.937
Perspective	.183	.383	.042	.478	.633
Bravery	-.342	.424	-.068	-.807	.421
Integrity	.808	.601	.125	1.344	.180
Kindness	-.115	.545	-.020	-.211	.833
Social intelligence	.836	.462	.170	1.810	.072
Fairness	-1.586	.530	-.285	-2.991	.003
Forgiveness and mercy	-.374	.336	-.091	-1.115	.266
Hope	.539	.395	.116	1.364	.174

Note. Big Five Personality Traits R^2 = .027 (p = .237. Dark Triad Personality Traits R^2 = .057 (p = .003). Character Strengths R^2 = .088 (p = .008).

Stigmatization of Borderline Personality Disorder

Analyses were conducted to assess the stigmatization of Borderline Personality Disorder. Familiarity with mental illness was not significantly associated with the stigmatization of Borderline Personality Disorder (r = -.063, p = .325, Table 12). Despite empathy being associated with stigmatization of mental illness, empathy was not found to be significantly associated with the stigmatization of Borderline Personality Disorder (r = -.117, p = .065, Table 12).

Table 12

Correlations of Stigmatization of Borderline Personality Disorder With Individual Characteristics

	r	p
Empathy	-.117	.065
Familiarity	-.063	.325

A multiple regression showed the Big Five personality traits had no relationship with the stigmatization of Borderline Personality Disorder (R^2 = .015, *p* = .588, Table 13). A multiple regression with the Dark Triad personality traits also showed no association with the stigmatization of Borderline Personality Disorder (R^2 = .008; *p* = .597, Table 13). Lastly, a multiple regression with selected character strengths were found to be related to the stigmatization of Borderline Personality Disorder (R^2 = .068, *p* = .047, Table 13). Hope was the only character strength found to be associated with the stigmatization of Borderline Personality Disorder (β = .229, *p* = .008), but the direction of the relationship was opposite from that which was hypothesized. No other character strengths included were found to be significantly related.

Table 13

Regression Analyses Summary for Individual Variables Predicting Stigmatization of Borderline Personality Disorder

Variable	B	SE B	Beta	t	p
Big Five Personality Traits					
Agreeableness	.029	.286	.007	.101	.919
Extraversion	.021	.457	.003	.045	.964
Conscientiousness	.645	.442	.112	1.459	.146
Neuroticism	.269	.340	.056	.791	.430

Table 13 (continued).

Variable	B	SE B	Beta	t	p
Openness to Experience	-.492	.393	-.082	-1.253	.211
Dark Triad Personality Traits					
Machiavellianism	-.183	.389	-.037	-.470	.639
Narcissism	.560	.412	.096	1.360	.175
Psychopathy	-.043	.409	-.008	-.105	.916
Character Strengths					
Open-mindedness	.509	.561	.085	.907	.365
Perspective	.036	.430	.007	.083	.934
Bravery	-.377	.477	-.068	-.791	.430
Integrity	.163	.676	.023	.242	.809
Kindness	.029	.612	.005	.048	.962
Social intelligence	.371	.519	.068	.715	.475
Fairness	-.930	.596	-.150	-1.560	.120
Forgiveness and mercy	-.435	.377	-.096	-1.155	.249
Hope	1.185	.444	.229	2.667	.008

Note. Big Five Personality Traits R^2 = .015 (p = .588). Dark Triad Personality Traits R^2 = .008 (p = .597). Character Strengths R^2 = .068 (p = .047).

Stigmatization of Schizophrenia

Analyses were conducted to assess the stigmatization of Schizophrenia. Familiarity with mental illness was not found to be significantly associated with the stigmatization of Schizophrenia (r = -.008, p = .903, Table 14). Empathy was found to be significantly negatively associated with the stigmatization of Schizophrenia (r = -.176, p = .005, Table 14).

Table 14

Correlations of Stigmatization of Schizophrenia With Individual Characteristics

	r	p
Empathy	-.176	.005
Familiarity	-.008	.903

A multiple regression with the Big Five personality traits showed no relationship with the stigmatization of Schizophrenia (R^2 = .037, p = .090, Table 15). A multiple regression with the Dark Triad personality traits indicated an association with the stigmatization of Schizophrenia (R^2 = .042; p = .015, Table 15). Although Machiavellianism and Psychopathy showed non-significant relationships, Narcissism was found to be positive associated with the stigmatization of Schizophrenia (β = .161, p = .021). Lastly, multiple regression with selected character strengths indicated that strengths were not related to the stigmatization of Schizophrenia (R^2 = .049, p = .201, Table 15).

Table 15

Regression Analyses Summary for Individual Variables Predicting Stigmatization of Schizophrenia

Variable	B	SE B	Beta	t	p
Big Five Personality Traits					
Agreeableness	.443	.255	.113	1.742	.083
Extraversion	-.624	.406	-.115	-.154	.126
Conscientiousness	.096	.394	.019	.244	.807
Neuroticism	-.462	.302	-.107	-1.530	.127
Openness to Experience	-.460	.349	-.085	-1.318	.189

Table 15 (continued).

Variable	B	SE B	Beta	t	p
Dark Triad Personality Traits					
Machiavellianism	.082	.344	.018	.239	.811
Narcissism	.849	.365	.161	2.328	.021
Psychopathy	.441	.361	.087	1.222	.223
Character Strengths					
Open-mindedness	-.426	.510	-.079	-.834	.405
Perspective	.101	.392	.023	.257	.797
Bravery	.540	.433	.108	1.246	.214
Integrity	.118	.615	.018	.193	.847
Kindness	-.275	.556	-.048	-.495	.621
Social intelligence	.419	.471	.085	.890	.374
Fairness	-.819	.541	-.147	-1.512	.132
Forgiveness and mercy	-.244	.342	-.060	-.714	.476
Hope	.023	.403	.005	.056	.955

Note. Big Five Personality Traits R^2 = .038 (p = .090). Dark Triad Personality Traits R^2 = .042 (p = .015). Character Strengths R^2 = .049 (p = .201).

CHAPTER IV

DISCUSSION

The current study assessed the relationships between individual characteristics, such as personality and character strengths, with the stigmatization of various mental illnesses. Exploratory factor analyses revealed a single Stigmatization factor for each disorder that encompasses the three stigmatization variables assessed (i.e., Dangerousness, Personal Responsibility, and Social Distance). The same single factor emerged regardless of which disorder (i.e., Major Depressive Disorder, Borderline Personality Disorder, Schizophrenia, and Leukemia) stigmatizing responses were made. This shows that while stigma is multidimensional in that it includes multiple attitudes (e.g., perceived dangerousness, social distance, personal responsibility attributed), it may also be understood as a unitary construct. No previous research has shown a single factor combining various dimensions of stigma. Furthermore, the three stigma factors that measure stigmatization of the mental illnesses assessed showed a single "Stigmatization of Mental Illness" factor. Thus, stigmatization of different mental illnesses may also be considered a unitary factor despite the range of mental illnesses it encompasses. While most other studies assess the stigmatization of a single disorder (e.g., Schizophrenia), a composite of multiple disorders may be more useful when generalizing to the stigmatization of mental illness in general.

Although previous research has found familiarity with mental illness to be associated with the stigmatization of mental illness (e.g., Brown, 2012; Corrigan et al., 2003; Phelan & Basow, 2007), no such relationship was found in the current study. Although this could be due to low variability of familiarity with mental illness in the

current sample, the descriptive statistics (i.e., skewness, kurtosis) for this variable do not appear to be problematic. This discrepancy with previous research may also be due to using a dimensional measure of familiarity which has only recently started to be used in research. As previously mentioned, most previous research has used a categorical measure of familiarity that only assesses if the respondent knows someone with a mental illness (e.g., Penn et al., 1994). Thus the relationship between familiarity and stigmatizing views may be less straightforward than originally considered and other aspects of contact with people with mental illness (e.g., type of contact, extent of relationship with the person) may be more important than simply whether they know someone with a mental illness.

Empathy was found to be related to the stigmatization of mental illness such that those with higher trait empathy endorse less stigmatizing attitudes toward individuals with mental illness. This is consistent with previous research and shows that those who are able to take another's perspective and experience other's distress vicariously have less stigmatizing and potentially harmful attitudes toward them. This finding is supportive of theories that suggest that empathy gives individuals a greater ability to recognize others' distress and increases concerns for them (Coke et al., 1978; Phelan & Basow, 2007) and thereby possibly improving attitudes toward them.

None of the Big Five personality traits were found to be related to the stigmatization of mental illness. Previous research found mixed results relating Big Five personality traits to prejudice and stigmatization suggesting at most, weak relationships, and sometime no relationship. Discrepancies may also be due to differences in statistical analyses (e.g., the current study used a multiple regression analysis with all five traits

whereas previous research used correlations or regressions with only significant traits). If one agrees that the stigmatization of mental illness is an exemplar of prejudice (e.g., Pescosolido et al., 2013), this finding fails to support the personality approach of prejudicial attitudes (Ekehammar & Akrami, 2003; Reynolds et al., 2001) at least in its relation to broad, normal-range personality traits such as the Big Five traits evaluated in the current study.

In the current study, Narcissism was related to the stigmatization of mental illness although Machiavellianism and Psychopathy were not. Thus, individuals who exhibit grandiosity and lack of concern for others tend to endorse stigmatizing attitudes. This may due to the need for superiority inherent in Narcissism while those who exhibit more Machiavellianism and Psychopathy characteristics are more willing to manipulate or dislike anyone, respectively, regardless of their characteristics (e.g., if they have a mental illness) Only one study was found that showed relationships between all three Dark Triad personality traits with prejudice (Hodson et al., 2009), but that study used correlations rather than a multiple regression analysis and thus may consider shared variance in the variables. No previous studies have assessed relationships between Dark Triad personality traits and the stigmatization of mental illness, and thus the current study adds to the knowledge base in this area. This finding may support the representation of prejudice as an expression of a type of maladjustment that is better explained with "darker personality variables" as noted by Hodson et al. (2009, p. 687).

Of the nine character strengths assessed in the current study, only Fairness was found to be related to the stigmatization of mental illness. Thus, those who seek to make unbiased decisions about others and tend to treat everyone the same endorse less

stigmatizing attitudes. While Fairness has been associated with greater prosocial and less antisocial behaviors and attitudes (Blasi, 1980), no previous research has assessed character strengths in relation to stigmatization. Biases in perceptions of others may thus be especially important when considering attitudes toward them.

Stigmatization was found to differ based on diagnosis. Major Depressive Disorder was found to be the least stigmatized of the three mental illnesses studied, followed by Schizophrenia and Borderline Personality Disorder. Thus different mental illnesses evoke different levels of stigmatizing attitudes. This result corresponds with hypotheses that Major Depressive Disorder would be least stigmatized due to familiarity and Borderline Personality Disorder would be most stigmatized due to lack of familiarity and the negative interpersonal behaviors associated with symptoms of this disorder.

Furthermore, patterns of the specific stigma variables varied across disorders. Specifically, targets with Major Depressive Disorder were seen as less dangerous than those with Schizophrenia and Borderline Personality Disorder, and Schizophrenia was seen as less Dangerous than Borderline Personality Disorder. Participants desired the least Social Distance from individuals with Major Depressive Disorder compared to targets with Schizophrenia and Borderline Personality Disorder. Findings related to both Dangerousness and Social Distance may be linked to differences in familiarity and understanding of the different disorders. Lastly, Schizophrenia was ranked as the least Personally Responsible followed by Major Depressive Disorder and then Borderline Personality Disorder. Thus people seem to recognize the biological underpinnings of Schizophrenia, but believe Borderline Personality Disorder is something that is more under the individual's control. Overall, the differences in stigma variables across

disorders suggest that not only do different mental illnesses evoke different levels of stigmatization in general, but different mental illnesses also evoke different patterns of stigmatization in terms of specific facets or dimensions of stigmatization. Published studies comparing stigmatization processes across different mental illnesses within the same sample are scarce, and none have assessed differences in specific facets of stigmatization across different mental illnesses. Thus the current study was the first to do so, and the results, demonstrating differences in stigmatization and specific stigmatizing attitudes across disorders, indicate that care must be taken when making generalizations of results to stigmatization of mental illness in general. Future research in this area should include more than one type of mental illness and should at least measure more than one facet of stigmatization, rather than simply using a single facet as a proxy for the more general construct.

To more closely examine the stigmatization of each mental illness, the current study examined the relationship between individual characteristics and stigma towards each mental illness separately. As with the stigmatization of mental illness, Narcissism was found to be positively associated with the stigmatization of Major Depressive Disorder and Fairness was found to be negatively associated with the stigmatization of Major Depressive Disorder. However, unlike with the stigmatization of mental illness, Empathy was not found to be related. This result, along with the finding that Major Depressive Disorder was the least stigmatized of the mental illnesses assessed, may reflect that Major Depressive Disorder is a well-known disorder and may thus not require much effort, or empathy, to not hold stigmatizing attitudes. When assessing the stigmatization of Borderline Personality Disorder, Hope was found to be positively

associated with stigmatization. This result, along with the high personal responsibility attributed to a target with Borderline Personality Disorder, may suggest the belief that if the person truly wanted to change, they could do so and that their lack of change is their own fault. Lastly, when examining the stigmatization of Schizophrenia, Empathy was found to negative associated with stigmatization and Narcissism was found to be positively associated with stigmatization, but no character strengths were found to be associated with stigmatization. This result, along with the least responsibility attributed to a target with Schizophrenia, may suggest that people view Schizophrenia as a biological disorder that, while they may be able to empathize with them, does not concern their own beliefs. These differences in the patterns of relationships of individual characteristics with the stigmatization of different mental illnesses further exemplifies that stigmatization may differ across disorders and limits to generalizability across disorders must be taken into consideration.

Limitations

Some limitations of this study include the sample used, measures chosen, the use of vignettes, and third variables. The sample was a convenience sample of undergraduate students from a single Southern university. Thus, results may not be generalizable to other populations. However, the use of an undergraduate sample may be beneficial in that participants are generally at the age where they may be making more independent decisions (e.g., seeking mental health services) relative to younger individuals. Thus, stigmatization may have more salience at this age than for younger individuals because there is a potentially increased risk that stigma may impede help seeking as college students no longer have adults bringing them to mental health care professionals. While

the use of undergraduate students may limit generalizability, it may still be an important population to examine, especially considering the high prevalence rates of mental illness among college students (e.g., Hunt & Eisenberg, 2010).

The use of self-report measures and potential social desirability may also influence results. Efforts were made to ensure adequate reliability and validity of measures when chosen. Additionally, measures were found to have adequate reliability in the current sample. Participants completed the study online and were informed their responses would be confidential in hopes of limiting social desirability bias in responses.

Another limitation is the use of a fictional vignette describing targets with mental illness. However, efforts were made to ensure vignettes included similar information except for differences in symptomology. Furthermore, the vignettes were validated in the pilot study, using graduate students trained in psychopathology, to ensure they described the disorder they were meant to illustrate.

Not all variables potentially related to the stigmatization of mental illness were assessed. Other variables that may be related to the stigmatization of mental illness include knowledge of facts about mental illness and familiarity with specific mental illnesses. Although the current study assessed familiarity with mental illness in general, specific knowledge about mental illness and familiarity with specific types of mental illness were not assessed. It is also important to note that stigmatizing responses may have been different if the name of the mental illness described had been explicitly labeled within the vignette. However, the intention of the current study was to evaluate stigmatizing responses to the portrayal of different types of symptoms associated with

mental illnesses, rather than simply stigmatization of mental illness labels, which was the reason diagnostic labels were not provided.

Implications

The results of the current study have implications for anti-stigma interventions. Because empathy was found to be related to stigmatization, anti-stigma interventions may be more effective if they increase empathic feelings toward targets. Additionally, Fairness and Hope were found to be related to stigmatization and thus interventions that promote treating everyone fairly and having positive expectations for the future may influence stigmatizing attitudes. Lastly, because Narcissism was found to be associated with stigmatizing attitudes, interventions may need to target individuals with higher levels at Narcissism while implementing an intervention that would appeal to these individuals. For example, when targeting individuals with higher levels of Narcissism, interventions may need to focus on providing objective information rather than attempting to increase empathy toward people with mental illness.

Future research may examine additional variables that may be related to the stigmatization of mental illness, including knowledge of mental illness and familiarity with the illness being assessed. Potential mechanisms for the role of familiarity may also be important. Also, research may wish to examine if there are differences in stigma between explicitly labeling a target with mental illness and targets not explicitly labeled. Future research may also examine whether manipulation of variables impacts stigmatizing attitudes. For example, research may examine if changes in stigmatizing attitudes occur from inducing empathic feelings toward a target, interacting with a target, or undergoing an intervention that promotes certain character strengths. Studies assessing

stigmatization should also use multiple mental illnesses and comparisons of attitudes associated with different mental illnesses, and the reasons underlying these attitudes, should be examined. Other methods for assessing stigmatizing attitudes should also be explored, including willingness to help a target with mental illness and physical distance when interacting with a target with mental illness.

In conclusion, the present study adds to the understanding of personality and character strengths and how they relate to the stigmatization of mental illness. Individual characteristics such as Empathy, Narcissism, Fairness, and Hope may be important when assessing stigmatizing attitudes toward people with mental illness. As the prevalence of mental illness fails to decline, it is necessary to understand factors that may inhibit treatment and progress for individuals experiencing such illnesses. The stigmatization of mental illness is an important factor to consider as it has impacts on individuals, their families, their treatment, and society. Efforts made to decrease this stigmatization may thus benefit from understanding who holds stigmatizing attitudes. This understanding can inform more targeted and effective interventions and improve the well-being of people with mental illness.

APPENDIX A

INSTITUTIONAL REVIEW BOARD NOTICE OF COMMITTEE ACTION

INSTITUTIONAL REVIEW BOARD
118 College Drive #5147 | Hattiesburg, MS 39406-0001
Phone: 601.266.5997 | Fax: 601.266.4377 | www.usm.edu/research/institutional.review.board

NOTICE OF COMMITTEE ACTION

The project has been reviewed by The University of Southern Mississippi Institutional Review Board in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services (45 CFR Part 46), and university guidelines to ensure adherence to the following criteria:

- The risks to subjects are minimized.
- The risks to subjects are reasonable in relation to the anticipated benefits.
- The selection of subjects is equitable.
- Informed consent is adequate and appropriately documented.
- Where appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of the subjects.
- Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of all data.
- Appropriate additional safeguards have been included to protect vulnerable subjects.
- Any unanticipated, serious, or continuing problems encountered regarding risks to subjects must be reported immediately, but not later than 10 days following the event. This should be reported to the IRB Office via the "Adverse Effect Report Form".
- If approved, the maximum period of approval is limited to twelve months.
  Projects that exceed this period must submit an application for renewal or continuation.

PROTOCOL NUMBER: 14070203
PROJECT TITLE: Personality, Character, and Attitudes
PROJECT TYPE: New Project
RESEARCHER(S): Jessica James
COLLEGE/DIVISION: College of Education and Psychology
DEPARTMENT: Psychology
FUNDING AGENCY/SPONSOR: N/A
IRB COMMITTEE ACTION: Expedited Review Approval
PERIOD OF APPROVAL: 07/17/2014 to 07/16/2015

Lawrence A. Hosman, Ph.D.
Institutional Review Board

APPENDIX B

VIGNETTES

Major Depressive Disorder

Christopher/Ashley is a 23-year-old college student. He/She is currently a psychology major. For the past year, Christopher/Ashley has been feeling really down. He/She used to enjoy hanging out with friends, but doesn't find it to be enjoyable anymore. He/She would rather stay in bed and sleep. Even though he/she usually gets over twelve hours of sleep a night, he/she still feels tired all day. Christopher/Ashley has been having difficulty concentrating and remembering things. He/She also has trouble making trivial decisions like what to have for lunch. Christopher/Ashley feels worthless and wonders if everyone would be better off if he/she hadn't been born.

Borderline Personality Disorder

Michael/Brittany is a 23-year-old college student. In the past year, Michael/Brittany has switched majors three times, from nursing to psychology to biology. He/She often feels empty and bored and needs to be doing something at every moment. Michael/Brittany hates to be alone and is usually with his/her best friend whom he/she describes as perfect. However, if they are ever a few minutes late, he/she gets very angry and accuses them of not caring about him/her and wanting to abandon him/her because he/she is “bad.” These feelings usually only last a few hours and he/she feels guilty about his/her outbursts afterward. Sometimes when this happens, Michael/Brittany starts drinking and goes bar-hopping. Michael/Brittany also occasionally scratches herself until he/she bleeds just so he/she can “feel something.

Schizophrenia

James/Jasmine is a 23-year-old college student. He/She is currently a business major, but is considering dropping out because he/she doesn't believe a degree is “worth it.” James/Jasmine is usually twirling his/her hair for no apparent reason. James/Jasmine believes that people are spying on him/her and want to harm him/her. He/She occasionally hears voices saying things like “you are worthless” and “we're going to find you.” His/Her grades have been slipping as he/she finds it difficult to focus on lectures because people are watching him/her. James/Jasmine also has difficulties expressing himself/herself and often jumps from one topic to another, unrelated topic.

Leukemia

Joshua/Kayla is a 23-year-old college student. He/She is currently a nursing major. Joshua/Kayla enjoys spending time with his/her friends. In the past year, Joshua/Kayla has been feeling very tired and weak. He/She gets sick frequently and has noticed he/she bruises easily and his/her neck feels swollen. He/She is frequently in the hospital and has started losing his/her hair.

APPENDIX C

CORRELATION MATRICES

Abbreviations:

Extrav	Extraversion
Agreea	Agreeableness
Consci	Conscientiousness
Neurot	Neuroticism
Openne	Openness to Experience
Machia	Machiavellianism
Narcis	Narcissism
Psycho	Psychopathy
Braver	Bravery
Fairne	Fairness
Forgiv	Forgiveness and Mercy
Hope	Hope
Integr	Integrity
Kindne	Kindness
Openmi	Open-mindedness
Perspe	Perspective
SocInt	Social Intelligence
Empath	Empathy
Famili	Familiarity with mental illness
MDDDan	Major Depressive Disorder: Dangerousness

MDDSco	Major Depressive Disorder: Social Distance
MDDRes	Major Depressive Disorder: Responsibility
MDDSti	Major Depressive Disorder: Stigma
BPDDan	Borderline Personality Disorder: Dangerousness
BPDSco	Borderline Personality Disorder: Social Distance
BPDRes	Borderline Personality Disorder: Responsibility
BPDSti	Borderline Personality Disorder: Stigma
SchDan	Schizophrenia : Dangerousness
SchSco	Schizophrenia: Social Distance
SchRes	Schizophrenia: Responsibility
SchSti	Leukemia: Stigma
LeuDan	Leukemia: Dangerousness
LeuSco	Leukemia: Social Distance
LeuRes	Leukemia: Responsibility
LeuSti	Leukemia: Stigma
GenDan	General Mental Illness: Dangerousness
GenSco	General Mental Illness: Social Distance
GenRes	General Mental Illness: Responsibility
GenSti	General Mental Illness: Stigma
**	$p < .050$
*	$p < .010$

Correlations Among Individual Characteristics

	Extrav	Agreea	Consci	Neurot	Openne
Extrav	–				
Agreea	.149*	–			
Consci	.199**	.519**	–		
Neurot	-.230**	-.357**	-.361**	–	
Openne	.113	.180**	.200**	-.059	–
Machia	.102	-.354**	-.143*	.244**	.040
Narcis	.480**	.037	.225**	-.175**	.159*
Psycho	.000	-.659**	-.412**	.278**	-.101
Braver	.500**	.183**	.375**	-.271**	.271**
Fairne	.157*	.590**	.397**	-.182**	.319**
Forgiv	.116	.655**	.251**	-.288**	.142*
Hope	.328**	.347**	.459**	-.490**	.186**
Integr	.200**	.462**	.500**	-.201**	.234**
Kindne	.274**	.609**	.348**	-.147*	.285**
Openmi	.152*	.400**	.529**	-.190**	.392**
Perspe	.189**	.334**	.454**	-.234**	.405**
SocInt	.544**	.377**	.415**	-.306**	.253**
Empath	-.042	.126*	-.021	.238**	.290**
Famili	.020	-.115	-.107	.272**	.151*

Correlations Among Individual Characteristics (continued).

	Machia	Narcis	Psycho	Braver	Fairne
Extrav					
Agreea					
Consci					
Neurot					
Openne					
Machia	–				
Narcis	.405**	–			
Psycho	.467**	.124*	–		
Braver	.038	.461**	-.030	–	
Fairne	-.255**	.061	-.482**	.390**	–
Forgiv	-.301**	.055	-.522**	.175**	.566**
Hope	-.109	.353**	-.233**	.532**	.419**
Integr	-.160*	.139*	-.396**	.498**	.642**
Kindne	-.216**	.119	-.446**	.357**	.637**
Openmi	-.008	.236**	-.323**	.403**	.542**
Perspe	.063	.332**	-.198**	.478**	.423**
SocInt	.045	.475**	-.196**	.579**	.436**
Empath	.220**	.082	-.038	.086	.259**
Famili	.132*	.023	.187**	.036	.012

Correlations Among Individual Characteristics (continued).

	Forgiv	Hope	Integr	Kindne	Openmi
Extrav					
Agreea					
Consci					
Neurot					
Openne					
Machia					
Narcis					
Psycho					
Braver					
Fairne					
Forgiv	–				
Hope	.386**	–			
Integr	.390**	.487**	–		
Kindne	.576**	.461**	.577**	–	
Openmi	.386**	.405**	.550**	.519**	–
Perspe	.303**	.498**	.500**	.407**	.645**
SocInt	.347**	.600**	.432**	.546**	.526**
Empath	.171**	.097	.115	.290**	.275**
Famili	-.132*	.143*	-.111	-.072	-.050

Correlations Among Individual Characteristics (continued).

	Perspe	SocInt	Empath	Famili
Extrav				
Agreea				
Consci				
Neurot				
Openne				
Machia				
Narcis				
Psycho				
Braver				
Fairne				
Forgiv				
Hope				
Integr				
Kindne				
Openmi				
Perspe	–			
SocInt	.546**	–		
Empath	.226**	.149*	–	
Famili	-.053	-.004	.120	–

Correlations Among Stigma Variables

	MDDDan	MDDSoc	MDDRes	MDDSti
MDDDan	–			
MDDSoc	.156*	–		
MDDRes	.171*	.147*	–	
MDDSti	.504**	.637**	.794**	–
BPDDan	.219**	.099	.213**	.258**
BPDSoc	.112	.434**	.066	.290**
BPDRes	.095	-.054	.419**	.284**
BPDSti	.172**	.207**	.346**	.386**
SchDan	.260**	.093	.198**	.259**
SchSoc	.027	.538**	.089	.331**
SchRes	.182**	-.014	.421**	.331**
SchSti	.211**	.311**	.405**	.448**
LeuDan	.227**	.037	.186**	.213**
LeuSoc	.106	.500**	.008	.283**
LeuRes	.132*	.148*	.246**	.279**
LeuSti	.205**	.360**	.221**	.387**
GenDan	.699**	.164**	.272**	.480**
GenSoc	.118	.787**	.121	.502**
GenRes	.193**	.032	.787**	.602**
GenSti	.365**	.477**	.641**	.775**

Correlations Among Stigma Variables (continued).

	BPDDan	BPDSoc	BPDRes	BPDSti
MDDDan				
MDDSoc				
MDDRes				
MDDSti				
BPDDan	–			
BPDSoc	.338**	–		
BPDRes	.278**	.212**	–	
BPDSti	.602**	.716**	.793**	–
SchDan	.301**	.118	.256**	.295**
SchSoc	.163**	.552**	.098	.377**
SchRes	.137*	.030	.365**	.275**
SchSti	.267**	.348**	.382**	.478**
LeuDan	.057	-.029	.103	.064
LeuSoc	-.071	.214**	-.020	.075
LeuRes	.000	.128*	.082	.114
LeuSti	-.019	.175**	.079	.130*
GenDan	.697**	.261**	.293**	.493**
GenSoc	.249**	.819**	.111	.541**
GenRes	.270**	.133*	.769**	.609**
GenSti	.482**	.579**	.625**	.799**

Correlations Among Stigma Variables (continued).

	SchDan	SchSoc	SchRes	SchSti
MDDDan				
MDDSoc				
MDDRes				
MDDSti				
BPDDan				
BPDSoc				
BPDRes				
BPDSti				
SchDan	–			
SchSoc	.295**	–		
SchRes	.049	.042	–	
SchSti	.497**	.656**	.719**	–
LeuDan	.067	-.077	.269**	.170**
LeuSoc	-.017	.369**	.127*	.286**
LeuRes	.062	.050	.302**	.256**
LeuSti	.052	.197**	.343**	.364**
GenDan	.739**	.229**	.172**	.462**
GenSoc	.207**	.853**	.024	.538**
GenRes	.216**	.098	.770**	.648**
GenSti	.436**	.568**	.546**	.815**

Correlations Among Stigma Variables (continued).

	LeuDan	LeuSoc	LeuRes	LeuSti
MDDDan				
MDDSoc				
MDDRes				
MDDSti				
BPDDan				
BPDSoc				
BPDRes				
BPDSti				
SchDan				
SchSoc				
SchRes				
SchSti				
LeuDan	–			
LeuSoc	.147*	–		
LeuRes	.277**	.163**	–	
LeuSti	.568**	.668**	.776**	–
GenDan	.166**	.010	.093	.114
GenSoc	-.030	.434**	.132*	.294**
GenRes	.242**	.050	.271**	.278**
GenSti	.184**	.265**	.268**	.363**

Correlations Among Stigma Variables (continued).

	GenDan	GenSoc	GenRes	GenSti
MDDDan				
MDDSoc				
MDDRes				
MDDSti				
BPDDan				
BPDSoc				
BPDRes				
BPDSti				
SchDan				
SchSoc				
SchRes				
SchSti				
LeuDan				
LeuSoc				
LeuRes				
LeuSti				
GenDan	–			
GenSoc	.268**	–		
GenRes	.316**	.110	–	
GenSti	.603**	.778**	.662**	–

Correlations Among Individual Characteristics and Stigma Variables

	MDDDan	MDDSoc	MDDRes	MDDSti
Extrav	.027	.049	.129*	.119
Agreea	.028	-.154*	-.002	-.070
Consci	.053	-.041	.037	.020
Neurot	-.016	.013	-.094	-.062
Openne	-.052	.077	-.033	-.001
Machia	.023	.173**	.096	.158*
Narcis	.035	.136*	.183**	.202**
Psycho	-.076	.167**	.135*	.150*
Braver	-.015	-.021	.082	.041
Fairne	-.088	-.140*	-.088	-.154**
Forgiv	-.003	-.189**	-.023	-.110
Hope	.084	-.053	.156*	.105
Integr	.010	-.031	.039	.015
Kindne	.009	-.145*	.033	-.047
Openmi	.004	.051	-.009	.020
Perspe	.018	.058	.053	.070
SocInt	.038	.020	.135*	.113
Empath	-.026	-.047	-.106	-.101
Famili	-.062	.022	-.079	-.061

Correlations Among Individual Characteristics and Stigma Variables (continued).

	BPDDan	BPDSoc	BPDRes	BPDSti
Extrav	.017	-.023	.029	.011
Agreea	.116	-.106	.094	.036
Consci	.138*	-.034	.109	.087
Neurot	.092	.014	-.019	.020
Openne	-.012	-.033	-.062	-.058
Machia	.035	.062	-.067	-.001
Narcis	.010	.020	.097	.072
Psycho	-.045	.032	-.033	-.016
Braver	.014	-.012	.118	.070
Fairne	.039	-.127*	.018	-.042
Forgiv	.032	-.158*	.056	-.036
Hope	.142*	.009	.243**	.191**
Integr	.106	-.073	.092	.048
Kindne	.136*	-.176**	.116	.019
Openmi	.083	.030	.105	.101
Perspe	.095	.045	.089	.102
SocInt	.113	.050	.119	.128*
Empath	-.049	-.128*	-.045	-.104
Famili	-.030	.032	-.109	-.059

Correlations Among Individual Characteristics and Stigma Variables (continued).

	SchDan	SchSoc	SchRes	SchSti
Extrav	.091	.081	.061	.117
Agreea	.132*	-.158*	-.032	-.066
Consci	.056	-.023	.007	.005
Neurot	-.086	-.029	-.068	-.092
Openne	.034	.069	-.192**	-.083
Machia	.026	.192**	.019	.126*
Narcis	.021	.126*	.141*	.179**
Psycho	-.089	.132*	.108	.118
Braver	.089	.100	-.036	.060
Fairne	.044	-.128*	-.139*	-.152*
Forgiv	.076	-.211**	-.071	-.136*
Hope	.009	-.051	.026	-.006
Integr	.094	-.061	-.084	-.065
Kindne	.138*	-.203**	-.068	-.111
Openmi	.033	-.013	-.128*	-.087
Perspe	.038	.061	-.098	-.019
SocInt	.078	.020	-.027	.018
Empath	-.086	-.060	-.158*	-.170**
Famili	-.043	.105	-.063	-.007

Correlations Among Individual Characteristics and Stigma Variables (continued).

	LeuDan	LeuSoc	LeuRes	LeuSti
Extrav	-.017	-.011	-.060	-.041
Agreea	-.217**	-.294**	-.162*	-.320**
Consci	-.158*	-.208**	-.093	-.214**
Neurot	.049	.015	-.096	-.033
Openne	-.171**	-.018	-.199**	-.189**
Machia	.073	.129*	.059	.130*
Narcis	.026	.082	.015	.063
Psycho	.123	.163**	.040	.153*
Braver	-.048	-.074	-.035	-.073
Fairne	-.113	-.258**	-.192**	-.288**
Forgiv	-.018	-.242**	-.130*	-.214**
Hope	-.063	-.144*	-.062	-.134
Integr	-.042	-.187**	-.078	-.156*
Kindne	-.137*	-.289**	-.197**	-.312**
Openmi	-.110	-.067	-.140*	-.156*
Perspe	-.061	-.099	-.060	-.107
SocInt	-.059	-.147*	-.056	-.127*
Empath	-.156**	-.197**	-.138*	-.236**
Famili	-.024	.015	-.225**	-.134*

Correlations Among Individual Characteristics and Stigma Variables (continued).

	GenDan	GenSoc	GenRes	GenSti
Extrav	.064	.043	.094	.101
Agreea	.129*	-.169**	.026	-.038
Consci	.114	-.041	.066	.048
Neurot	-.008	-.001	-.077	-.054
Openne	-.014	.043	-.125*	-.059
Machia	.039	.172**	.020	.114
Narcis	.031	.113	.181**	.187**
Psycho	-.099	.132*	.090	.101
Braver	.042	.029	.070	.073
Fairne	-.003	-.160*	-.090	-.143*
Forgiv	.050	-.227**	-.016	-.115
Hope	.108	.182**	-.037	.126*
Integr	.097	-.068	.020	-.000
Kindne	.131*	-.214**	.034	-.055
Openmi	.055	.027	-.014	.018
Perspe	.069	.067	.019	.067
SocInt	.106	.038	.097	.110
Empath	-.075	-.097	-.133*	-.157*
Famili	-.064	.065	-.108	-.057

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