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Stigma and Discrimination Based on Mental Health Status: The Impact of Familiarity, Attitudes, and Social Norms/Influence

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Abstract

Individuals with psychological disorders must work to make a living just like everyone else. However, despite potential advantages of self-disclosure, the threat of public stigma may impact the decision to reveal their disability status to their co-workers, with many opting for concealment. Research suggests that this concern may be justified; stigma and discrimination based on mental health status have been noted to occur in the workplace, particularly when co-workers have less direct experience with mental health diagnoses. The purpose of the present literature review is to identify factors that may contribute to the likelihood of individuals with psychological disorders experiencing discrimination in the workplace based on their disclosure. Specifically, we explore the relative impacts of familiarity, attitudes, and social norms/influence on stigma against individuals with psychological disorders. Further, we propose a theoretical framework which suggests a cyclical relationship between familiarity, attitudes, and social norms/influence in creating, perpetuating, and reducing public stigma towards individuals with psychological disorders. This framework is applied to the workplace environment to identify the pathways through which stigma may be perpetuated as well as reduced. Additionally, we outline the methodology for a preliminary study which may be conducted in the future to test the factors posited by the present theoretical framework and assess their influence in the workplace environment. Finally, we suggest strategies for the reduction of mental health stigma in the workplace.

Stigma and Discrimination Based on Mental Health Status: The Impact of Familiarity, Attitudes, and Social Norms/Influence

Introduction

The process of social categorization, the division of people into "us" and "them," is what lays the foundation for prejudice (Tajfel et al., 1971). Those individuals with whom we identify are part of our in-group; they are one of "us." Conversely, those individuals whom we deem distinctly different from ourselves are part of an out-group; they are labeled as "other." Even in the absence of outright prejudice, the establishment of "us" versus "other" facilitates favoritism of in-groups and differential treatment towards out-groups (Tajfel et al., 1971). Ultimately, those whose differences pose a threat to our sense of self, social identity, or feelings of security are perceived negatively. These are the individuals and groups towards whom prejudices are formed.

One specific area of otherness revolves around the idea of ability. The terms "able-bodied" and "disabled" are two sides of the same coin. Each label refers to a distinct social category to which people can belong. There are many different subcategories that fall under the umbrella term of "disabled," including but not limited to: specific learning disabilities, intellectual disabilities, orthopedic impairments, autism spectrum disorder, psychological disorders, visual impairments, and other health impairments (Dragoo, 2020). But of all these disabilities, whether visible or invisible, there is one thing that they have in common: they diverge from what is considered "normal."

The dichotomy between "normal" and "abnormal" has existed throughout history, and one institution that historically "…[constructed] an exaggerated divide between 'normal' and Other…" was the freak show (Clare, 1999). Freak shows thrived off the concept of visible human difference, accentuating individuals' physical "abnormalities" to sell them as spectacles

for entertainment. Paying customers came to freak shows to be "…educated and entertained, titillated and repulsed", but mostly "… to have their ideas of normal and abnormal, superior and inferior, their sense of self, confirmed and strengthened" (Clare, 1999). This othering of individuals with disabilities in freak shows carried over into everyday life. Anyone considered to be "disabled" was negatively associated with concepts like undesirability, inferiority, and/or incompetence (Clare, 1999).

As illustrated by the aforementioned example, ideas of "us" and "them" are often formed based on visible differences. However, the social categorization that breeds prejudice is more challenging when it is less clear who is able-bodied and who is "disabled." While many disabilities have clearly defining physical features that facilitate the dichotomous social categorization of "able-bodied" and "disabled", there are others which are less obvious; these have been labeled "invisible disabilities". A disability is considered invisible if it is not visible from the outside, yet still limits or challenges an individual's experiences in everyday life (Invisible Disabilities Association, 2010). One subcategory of disability classified as invisible is psychological disorders, a term that has more recently acted as a politically correct substitute for the term "mental illness". The National Institute of Mental Health (2022) defines mental illness as a "…mental, behavioral, or emotional disorder" which can "…vary in impact, ranging from no impairment to mild, moderate, and even severe impairment". In 2020, around 52.9 million adults in the United States, nearly one in five adults, reported having a mental illness (National Institute of Mental Health, 2022). But even though these diagnoses are so common, individuals with psychological disorders still face the stigma attached to the word "disability" as well as the negative connotations related with the term "mental illness." As a result, individuals with

psychological disorders may opt to keep their clinical diagnosis private to avoid potential prejudice and discrimination from others.

Stigma associated with mental health diagnosis is a serious issue with many implications for mental health and interpersonal well-being. Two types of stigmas that could potentially affect individuals with mental health problems are 1) public stigma and 2) self-stigma. Public stigma has been described as "…the stereotypes, prejudice, and discrimination endorsed by the population…" that are directed towards the members of a particular social group (Corrigan & Nieweglowski, 2019). Meanwhile, self-stigma is defined as the internalization of public stigma, which often leads to a loss of self-esteem, self-efficacy, and confidence in oneself (Ben-Zeev et al., 2010). Both types of stigma are equally harmful due to their negative impacts on the individuals receiving the stigma from others.

One place that both public and self-stigma may be of particular concern is in the workplace. Though relatively limited in recent years, research on both the anticipated and actual effects of mental health status disclosure provides empirical evidence for the detrimental effects of workplace stigma and discrimination based on mental health status. In 2010, The UK National Labor Force Survey found that only about 20% of people with psychological disorders were employed (Wheat et al., 2010). This low employment rate directly reflects workplace discrimination against individuals with psychological disorders. According to Wheat and colleagues (2010), one-third of individuals with psychological disorders were fired or forced to resign from their jobs and 40% were denied jobs because of their diagnosis and treatment history.

Stigma related to mental health, whether it be perceived or actual, can prevent employees from disclosing their diagnosis to others. A recent study by Dewa and colleagues (2021)

surveyed 332 employed individuals who indicated they had personal experience with mental health problems. Of all the participants, 89 individuals (26.8%) decided not to disclose their diagnosis to their superior. Among the 243 workers who did disclose their mental health diagnosis to superiors, 87.7% (n = 213) of them claimed that their disclosure decision had positive outcomes (e.g., received managerial support). However, for the 12.4% (n = 30) of participants who had a negative experience from disclosure, the stigma related to mental health presented real problems. For example, 20 individuals claimed that their managers were unsupportive, 14 individuals lost their jobs, and 8 individuals claimed that their disclosure had a negative impact on their workplace relationships (Dewa et al., 2021). The results of this study demonstrate the very real impact that prejudice and discrimination can have on the experiences of individuals with psychological disorders as they navigate the workplace environment.

The present review will analyze the potential costs and benefits to disclosure of mental health diagnosis in the workplace and workplace factors that may contribute to negative outcomes associated with disclosure. A theoretical model for the proposed interactions among attitude strength, familiarity, and social influence will be presented as a framework for understanding interpersonal dynamics surrounding mental health disclosure, and potential applications of this model in the workplace will be discussed.

Disclosure of Mental Health Diagnosis: Perceptions and Reality

Public Stigma and Attitudes Toward Psychological Disorders

While public stigma can target any social identity, individuals with psychological disorders may be particularly vulnerable to negative social repercussions due to the relative lack of understanding the general public has of different mental health diagnoses. In 2012, Durand-Zaleski and colleagues assessed the beliefs and attitudes that French citizens (n = 916) held

towards three specific psychological disorders: schizophrenia, bipolar disorder, and autism. When asked about whether they recognized the names of the disorders, 100% of participants recognized the term “autism”, 97% recognized “schizophrenia”, and 96% recognized “bipolar disorder”. However, when participants were asked whether they could provide specific characteristics or features of these disorders, the responses decreased to 67% for autism, 53% for schizophrenia, and 43% for bipolar disorder. Moreover, 30% of participants referred to the media as a frequent source of information on psychological disorders, ahead of doctors (27%) and health professionals (21%; Durand-Zaleski et al., 2012). Individuals that refer to the media as their main source of information about mental health diagnoses are more likely to be misinformed by negative stereotypes (e.g., people with schizophrenia are dangerous; Behm-Morawitz, 2020).

Three specific dimensions which are prevalent in the creation and perpetuation of public stigma toward mental illness include: personal responsibility, dangerousness, and rarity (Feldman & Crandall, 2007). Research on the influence of these three dimensions revealed that individuals were more willing to socially reject those with psychological disorders when their specific psychiatric diagnosis was perceived to be high on any of the three dimensions (Feldman & Crandall, 2007). Other research has examined the specific relationship between perceived levels of humanity and perceived dangerousness, revealing the specific conditions under which individuals with psychological disorders would be socially rejected (Martinez et al., 2011). Study 1 revealed that a general “mental illness” label was associated with less humanity, which was a predictor of increased perceptions of dangerousness. In Study 2, participants formed impressions about individuals with a specific psychological disorder, who behaved “normally” and were in remission. These individuals were associated with greater levels of humanity and decreased

perceptions of dangerousness. Ultimately, individuals who were perceived as having low levels of humanity and perceived as highly dangerous were socially rejected (Martinez et al., 2011). But the closer that the individual seemed to "normal", meaning they were associated with high levels of humanity and not perceived as dangerous, the closer they were to being socially accepted and treated as an in-group member.

Media Portrayals of Psychological Disorders

It is evident that the media (e.g., movies, television shows, etc.) acts as an important source of information for many individuals. In a study by Corrigan, Green, and colleagues (2001), out of 208 participants, over 90% of individuals reported learning about mental health diagnoses from movies. In a different study by Durand-Zaleski and colleagues (2012), out of 916 participants, 30% rated the media as a frequent source of information on mental health diagnoses. The findings from both studies present striking implications for public perceptions of mental health diagnoses, especially because media portrayals of mental health tend to be full of misconceptions and misrepresentations. In essence, individuals that rely on the media as their main source of information about mental health are bound to be misinformed about the reality of those with mental health diagnoses.

Media portrayals of individuals with psychological disorders are often based upon negative stereotypes. In a study by Quintero Johnson and Riles (2018), 359 college students completed an online survey which assessed their perceptions of those with mental health diagnoses in relation to media depictions of those with diagnoses. Results revealed the frequency with which participants associated media depictions of mental health diagnoses with different characteristics. Among these characteristics were seven stereotypic attributes including: violent or dangerous behavior (8.4%), crazy (6.7%), childlike (7.8%), evil (0.9%), lacking in self-

reliance (1.4%), anger and outbursts (6.4%), and stigmatized (0.3%). Of all the participants, 27.8% (n = 96) described media characters with mental health diagnoses using these stereotypic attributes, the most mentioned attributes being violent or dangerous behaviors and "crazy" (Quintero Johnson & Riles, 2018). These research findings demonstrate the prevalence of negative stereotypes in the media, a fact which could be problematic should it lead the public to base their judgments about real-world individuals with psychological disorders off gross misrepresentations (Behm-Morawitz, 2020). For someone with little or no personal contact with individuals with psychological disorders, the likelihood of this occurring could be increased.

Self-Stigma and The Effects of Labels

After an individual receives a clinical diagnosis, they tend to become painfully aware of the multitude of stigmatizing images found in our society. These images and notions have the power to negatively affect the everyday life of individuals with psychological disorders, causing them to feel incapable of achieving their goals and unworthy of their rewards should they achieve them (Ben-Zeev et al., 2010). A major deterrent for individuals deciding whether to self-disclose is the label of "mental illness" itself. The negative connotations associated with the term often lead people to engage in label avoidance. Label avoidance occurs when people deny themselves the help of mental health services because they want to avoid the potential negative impact of being directly associated with the label of "mental illness" (Ben-Zeev et al., 2010). People fear that taking advantage of available mental health services will deem them a "mental patient" and make them a target for prejudice and discrimination. Frequently, people find hiding their diagnosis and not receiving help preferable to suffering public stigma.

When it comes to labeling, the way that people are perceived is dependent upon the type of language utilized for the label. Person-first language allows an individual to maintain their

humanity, separating themselves from the illness (e.g., an individual who has a mental illness or psychological disorder). Conversely, diagnosis-first language makes the individual and their diagnosis appear to be one and the same, virtually inseparable from one another (e.g., they are mentally ill; Jensen et al., 2013). Research on stigma has revealed that diagnosis-first language contributes to the perpetuation of stigma and negative attitudes towards those with disabilities (remember that psychological disorders are considered invisible disabilities; Jensen et al., 2013). Words can create barriers, misperceptions, stereotypes, and labels that are difficult to overcome. Labels promote social categorization and further the divide between ingroups and outgroups ("us" and "them," respectively). Overall, the language that an individual uses when referring to those with mental health diagnoses can be very telling about their attitudes toward mental health.

Stereotype Threat

Stereotype threat is a phenomenon which may be experienced by members of any group about whom negative stereotypes exist, typically experienced as the "…self-evaluative apprehension or a fear of confirming a negative stereotype about one's group through one's own behavior" (Roberson et al., 2003). Stereotype threat is situation-specific, being activated primarily while an individual is engaged in a task and is consciously aware of a negative stereotype about their identity group that is relevant to the performance of this task. When activated, the apprehension associated with the potential to inadvertently confirm the negative stereotype draws attention away from the task at hand and towards the concern over one's performance. Research on stereotype threat in the workplace has shown that the awareness of societal stereotypes can have a negative effect on employee performance (Roberson & Kulik, 2007).

However, the awareness of societal stereotypes and the expectation to perform a stereotype-relevant task are not enough to create stereotype threat. Research has identified two factors that can affect the likelihood that stereotype threat will occur: task difficulty and context (Roberson & Kulik, 2007). Stereotype threat is most likely to influence performance on very difficult tasks, especially those that cause individuals frustration. When a member of a stereotyped group experiences frustration with a task, the salience of negative stereotypes and the fear of confirming them may occupy their thoughts (e.g., "If I can't do this, will everyone else think this stereotype is true?"). Difficult tasks require concentration and focus, mental resources that may be redirected toward the apprehension associated with stereotype threat rather than being applied to the task at hand. This redirection towards stereotype threat and away from the task can lead to declines in performance (Roberson & Kulik, 2007).

Moreover, the context in which a task is performed may influence the salience of a particular stereotype. More specifically, the different demographics represented in a particular context can affect the relevance of stereotypes. A study by Roberson and colleagues (2003) assessed whether African American professionals experienced stereotype threat for racial stereotypes in a workplace environment. Results revealed that African American professionals who were the sole representatives for their racial group (solo status) experienced a greater amount of stereotype threat on the job (Roberson et al., 2003). These findings suggest that perceptions of stereotype threat are influenced by contextual variables such as demographic diversity, or a lack thereof. In a workplace that is predominantly staffed by White employees, BIPOC (Black, Indigenous, and people of color) individuals may assume the role of "tokens". The term "token" has been used to describe "…individuals who are different from others on a salient demographic dimension…" and tend to feel "visible" when surrounded by others

(Roberson & Kulik, 2007). Since, by definition, tokens are few in number, their performance can come to represent the competence and/or ability of their entire identity group. The pressure that accompanies being the sole representative of one's group can reinforce the relevance of particular stereotypes and increase the likelihood of stereotype threat.

Although there are currently no studies looking directly at stereotype threat associated with psychological disorders in the workplace, research on other stigmatized identities suggests that the same processes would apply. For individuals with psychological disorders, solo (token) status is an experience that may occur regardless of whether an individual decides to disclose their psychiatric diagnosis to coworkers. By not disclosing, individuals can avoid openly identifying and being associated with other individuals with psychological disorders. However, they may still internalize any negative stereotypes associated with their performance and experience self-stigma. For an individual that decides to disclose, they open themselves to becoming the token representatives of those with psychological disorders, increasing their actual or perceived visibility as well as the likelihood of stereotype threat negatively influencing job performance.

Disadvantages Associated with Disclosing vs. Not Disclosing

With the potential for stigma (both public and self) as well as all the negative outcomes associated with people's erroneous negative assumptions/stereotypes about individuals with psychological disorders, one might assume it is in the best interest of these individuals to not disclose their mental health diagnoses to others. An article by Corrigan and Watson (2002) outlines the obstacles that individuals with psychological disorders face. On one hand, these individuals struggle with the symptoms and disabilities that result from their diagnosis. On the other, they are constantly challenged by the stereotypes and prejudices that result from

misconceptions about the term “mental illness” (Corrigan & Watson, 2002). Oftentimes, the decision to self-disclose one’s diagnosis to others creates social barriers, adding more difficulties to the ones already created by their own symptoms. Many individuals with psychological disorders are robbed of opportunities because their diagnosis is public knowledge. For example, they may be denied good jobs, safe housing, sufficient health care, and many other resources and opportunities that can provide a quality of life (Corrigan & Watson, 2002).

Conversely, there are also disadvantages to refraining from disclosure. These may include psychological strain and feelings of isolation, fraud, and fear of discovery (Smart & Wegner, 2000). In turn, these feelings may lead to self-isolation, self-detriment, feelings of guilt, and paranoia. None of these are healthy behaviors to maintain. Overall, withholding information from peers can impede the development and maintenance of interpersonal relationships (Smart & Wegner, 2000). The hope would be that self-disclosure would free an individual of this inner turmoil and social alienation, but we have already seen the disadvantages of transparency. Regardless of what they choose to do, individuals with psychological disorders face daily challenges.

Role of the Workplace

Workplace discrimination occurs based on a myriad of factors that are beyond an individual’s control, including race/ethnicity, religion, gender identity, sexual orientation, national origin, disability, and age (U.S. Equal Employment Opportunity Commission). However, despite its disability classification, psychiatric diagnosis remains understudied in terms of workplace discrimination. Two areas that warrant further exploration are the creation and perpetuation of public and self-stigma against individuals with psychological disorders in the workplace. The disadvantages of self-stigma outlined above, including diminished self-esteem

and self-efficacy, can negatively impact an individual's performance and success in the workplace. But a major reason why individuals decide not to self-disclose their psychological disorders is that they anticipate the social rejection associated with public stigma. The expectation for social rejection makes self-disclosure appear disadvantageous.

Understanding how, when, and why stigmatizing behavior is likely to occur is the first step to creating the perception of a welcoming workplace and, in turn, potentially encouraging disclosure. Three factors that may contribute importantly to stigma in the workplace are level of personal familiarity with/understanding of mental health diagnoses, social influence factors, and strength of initial attitudes toward mental health diagnoses.

Three Potential Avenues Toward Stigma: Familiarity, Attitude Strength, and Social Norms/Influence

Familiarity and Stigma

From a social psychological perspective, stigma may have its foundational origins in the schemas we form for unfamiliar groups. Schemas are "…the unconscious mental structures and processes that underlie the molar aspects of human knowledge and skill" (Brewer & Nakamura, 1984). These mental structures come in various forms (e.g., stereotypes, stories) and are used to organize our experiences, filtering new incoming information through old, already-accepted information (Calhoun et al., 2014). Once formed, schemas can be invoked automatically to process new information more efficiently, allowing us to conserve mental resources rather than drawing on our more effortful controlled processing. Because we tend to process information through the lens of these schemas, they can be very difficult to alter once formed; mechanisms such as confirmation bias (i.e., when we have a schema in mind, we remember things that confirm our schema and ignore/forget the things that do not) may influence us to notice, think

about, and remember information that aligns with the schema (Aronson et al., 2022). For example, research shows that individuals with more developed schema for a body of knowledge will exhibit higher recall for schema-related information than schema-unrelated information (Brewer & Nakamura, 1984). It is thus important to consider where and how individuals form their initial schemas for individuals with psychological disorders, and how these may impact their perceptions of and behavior toward those with psychological disorders in the workplace.

Individuals may form schemas about mental health around their knowledge of and personal experience with those with mental health diagnoses. In essence, their schemas will be formed based upon their level of familiarity, which varies in intensity from person to person (Corrigan, Edwards, et al., 2001). Research by Corrigan, Green, and colleagues (2001) revealed that familiarity is inversely related to two constructs: social distance and perceived dangerousness. The more familiar that a participant was with mental health diagnoses, the less likely they were to socially distance themselves or believe that people with psychological disorders were dangerous. Thus, individuals that are more familiar with mental health diagnoses are less likely to engage in public stigma towards this group. Conversely, individuals with less familiarity would be more susceptible to forming biased schemas, as the information used to form their schemas would likely come from media portrayals of mental health. In fact, Corrigan, Green, and colleagues (2001) found that more than 90% of participants reported learning about mental health diagnoses through the media, which as previously outlined, tends to reinforce negative stereotypes by representing individuals with psychological disorders as dangerous. Individuals that are less familiar with mental health diagnoses, especially those with biased schemas, would be more likely to socially distance themselves, believe that those with

psychological disorders are dangerous (negative stereotype), and engage in public stigma towards this group.

An empirically valid and reliable measure of familiarity is the Level of Contact Report, a measure developed to assess level of familiarity with individuals with psychological disorders (Holmes et al., 1999). The measure lists 12 situations that vary from least familiar ("I have never observed a person that I was aware had a serious mental illness"), to medium familiarity ("I have worked with a person who has a serious mental illness at my place of employment"), to high familiarity ("I have a severe mental illness"; Holmes et al., 1999). Familiarity increases the more personal that the relationship with mental health diagnoses becomes. According to the Level of Contact Report, having worked with a person with a psychological disorder qualifies as having a medium level of familiarity. However, this level of familiarity can only be obtained if the individual with the diagnosis decides to disclose. Given many individuals' hesitance to disclose and the general lack of workplace trainings familiarizing individuals with the concept of mental health diagnoses (Greenwood et al., 2019), co-workers' access to information on individuals with psychological disorders and, thus, levels of familiarity would be limited to their own personal knowledge of and experiences with mental health from outside the workplace.

Attitudes and Attitude Change

Concerning public attitudes toward mental health, stigma in the workplace can be affected by both or either of two potential issues: 1) the influence of existing prejudices which were formed prior to interactions in the workplace environment, and 2) weak or ambivalent attitudes due to low familiarity with mental health diagnoses. Both issues are contingent on attitude strength, which refers to the durability (i.e., general resistance to change, temporal persistence, and stability over time) and impact (i.e., influence over an individual's thoughts and

behaviors) of an attitude (Tormala & Rucker, 2017). Generally, those with strong existing prejudices/attitudes are resistant to change (e.g., via persuasion or other social influence), while individuals with weak or ambivalent attitudes tend to be more susceptible to attitude change (Luttrell & Sawicki, 2020). When trying to make a workplace environment more inclusive and welcoming, it may prove challenging to change the minds of those with strong existing prejudices. The rest of this section explores two attributes that correlate with attitude strength outcomes and their importance to changing attitudes: ambivalence and certainty.

Attitudinal ambivalence is defined as "…a state in which an individual 'is inclined to give it [an attitude object] equivalently strong positive or negative evaluations'", generally resulting in an experience of mixed and conflicted feelings toward the attitude object (Armitage & Conner, 2000; Luttrell & Sawicki, 2020). Armitage and Conner (2000) conducted two studies on global measures of ambivalence to assess the effects of attitudinal ambivalence on attitude stability, pliability, and influence on subsequent behaviors. Results revealed that univalent attitudes (i.e., either a primarily positive or negative reaction to an attitude object; less ambivalent) were both more predictive of subsequent behaviors and less susceptible (more resistant) to persuasion. On the flip side, ambivalent attitudes were more susceptible to persuasion (Armitage & Conner, 2000).

Furthermore, attitude certainty refers to "…the subjective sense of confidence or conviction one has about an attitude," and has been shown to affect an individual's thoughts, feelings, evaluations, and actions towards a particular attitude object (Tormala & Rucker, 2017). Like ambivalence, attitude certainty can affect the degree to which individuals' attitudes drive their behavior and resist change. Individuals form, appraise, and change their attitude certainty based upon information and evidence related to several different attributes, including accuracy

and their subjective experience with the retrieval or use of their attitudes. Generally, people tend to be more certain of their attitudes when they believe that attitude-relevant information is accurate (confirms their beliefs) and easily processed (easier to retrieve/generate arguments; Tormala & Rucker, 2017). Individuals' interpretation of attitude-relevant information depends upon the confirmation or refutation of their schemas. As mentioned earlier, we tend to process information through the lens of schemas, which are typically formed based on information from the media and/or personal experience. Once an individual's schema has formed, mechanisms such as confirmation bias can strengthen the certainty with which a particular attitude is held. Regarding attitude strength, attitudes held with high certainty tend to have the characteristics of strong attitudes, being more durable and impactful. Attitudes with high certainty are more resistant to change via persuasion or other forms of social influence and more predictive of behavior.

Further, since low certainty (uncertainty) decreases resistance to change, it opens individuals up to persuasion in the context of affective-cognitive matching (i.e., when persuasive appeals match the affective or cognitive basis of the attitude; Tormala & Rucker, 2017). Affective-cognitive matching is one potential method of changing attitudes in the workplace. Appealing to people's emotions is most effective when the attitude is emotionally based and appealing to logic is most effective when the attitude is more cognitively based. In the context of the workplace, individuals that have weak or ambivalent attitudes towards mental health and are uncertain of their attitudes should be more open to persuasion. If one such individual received their information from a movie that portrayed individuals with mental health diagnoses as dangerous, that may have evoked a feeling of fear. If prejudicial attitudes are formed based around this feeling of fear, then that attitude would be more affectively based. To sway their

perceptions from a negatively skewed view to a more positive view, a persuasive argument that appeals to their emotions should be more effective than presenting facts and figures.

Alluding back to the two potential issues regarding stigma in the workplace, strong attitudes as well as weak/ambivalent attitudes each present their own challenges. First, strong attitudes (high certainty) against individuals with psychological disorders which existed prior to interactions in the workplace would be expected to be resistant to change and more predictive of behavior. If these individuals had prejudices toward those with psychological disorders, it may be more difficult to change their mind towards tolerance. Any attempt to change their attitudes would need to be through an emotion-targeting or interaction-based approach, which could be harder to facilitate in a workplace environment. As a result, these individuals may be more likely to allow their prejudices to manifest into discriminatory practices. Second, weak or ambivalent attitudes due to low familiarity would be expected to be more susceptible to persuasion. The problem would lie in whether the information swaying individuals portrayed those with psychological disorders in a negative light (e.g., misrepresentation of mental health diagnoses in the media) or a positive one, as might be accomplished through targeted workplace intervention.

Social Norms and Social Influence

Social norms are defined as "…the beliefs a group has about acceptable attitudes and behaviors" (including how to think and behave toward members of stigmatized groups) and has been shown to influence an individual's social distance from those stigmatized groups (Manago & Krendl, 2022; Norman et al., 2008). Recent research by Norman and colleagues (2008) examined the association between perceived social norms and beliefs about mental health diagnoses as predictors of social distance towards individuals with schizophrenia compared to those with depression. The specific social norms under investigation were injunctive norms (i.e.,

reflect perceptions of what others would approve of) and descriptive norms (i.e., reflect what others actually do). Results revealed that perceived social norms which favored greater social distance were positively correlated with "…belief in danger, social inappropriateness, personal responsibility, and lower talent or intelligence" (Norman et al., 2008). Further, the greater the belief that those in participants' close social networks would disapprove of and not engage with an individual with schizophrenia or depression (descriptive norm), the greater the social distance.

An interesting finding of Norman and colleagues' study was the individual contribution that perceived social norms made to the desire for social distance. Personal beliefs alone accounted for 29% of social distance from those with schizophrenia and 13% from those with depression. When perceived social norms were added, this preference increased to 51% for social distance from those with schizophrenia and 34% from those with depression (Norman et al., 2008). These results demonstrate the ability of social norms to influence subsequent behavior, although they only show the negative influence that social norms can have. Social norms are also capable of having a positive influence by helping to decrease the stigma towards individuals with psychological disorders.

A study by Manago and Krendl (2022) sought to examine whether the perception of positive social norms would be associated with increased contact and, consequently, decreased stigma for those with psychological disorders. To preface, positive direct contact involves interactions between an individual with a specific outgroup member (e.g., family member, friend with a psychological disorder) and is one of the most effective ways proven to reduce prejudice, including mental health stigma. Research demonstrates that contact reduces stigma as well as negative emotions held towards individuals with psychological disorders, specifically fear caused by perceptions of dangerousness and unpredictability (Manago & Krendl, 2022).

However, contact is difficult to facilitate in real-world settings because of barriers such as the unwillingness of prejudiced individuals to interact with outgroup members. The experiment conducted by Manago and Krendl (2022) was an effort to circumvent the difficulty of facilitating contact alone by exploring the alteration of social norms as an alternative to reducing prejudice. The hope was that social norms that involve more positive evaluations of outgroup members (termed "improved norms") could be associated with increased contact through two possible pathways: 1) improved norms would positively predict the willingness to disclose mental health diagnoses to friends, and 2) improved norms would increase the willingness to interact with and befriend outgroup members (Manago & Krendl, 2022). Results revealed that perceptions of improved social norms were associated with a decrease in social distance through increased contact. Ultimately, these results demonstrated the promise of positive social norms in reducing stigma towards individuals with psychological disorders.

Along the same vein of the potential for mental health stigma reduction, social influence also provides promise. Two types of social influence have been assessed to determine their influence in attitude change: informational social influence and normative social influence. Prior research has demonstrated that increased ambiguity leads to increased conformity (Zitek & Hebl, 2007). For example, when individuals do not know how to respond to a situation (e.g., an emergency), they look to others for guidance and mimic their behavior (e.g., exit through the nearest door). This is a classic explanation of informational social influence, where people use others as a source of accurate information and conform to their views. Meanwhile, normative social influence occurs when people conform to group norms with the specific goal of being accepted by others and avoiding rejection. This type of conformity is typically reflected in observable behavior, but not necessarily in privately held attitudes. Between the two types of

social influence, informational social influence is thought to be more likely to lead to private acceptance and longer-term attitude change (Aronson et al., 2022).

However, there is a specific mechanism of social norms which can predict the extent to which individuals will be susceptible to social influence: the clarity of social norms. Societally, the expectations of what is an acceptable reaction differs by target group. A study by Zitek and Hebl (2007) looked at how the clarity of social norms regarding the acceptability of displaying prejudices affects reactions to social influence attempts. Participants heard a confederate either condone, condemn, or give no opinions about discrimination toward social groups associated with varying levels of social norm clarity. For example, it is widely known (the norm is very clear) that a public display of prejudice towards Black individuals denotes the endorsement of racism. But some norms are not as widely known (more ambiguous), like how to conduct oneself when expressing beliefs about ex-convicts. Results revealed that as the social norm became more ambiguous, participants were more likely to be influenced by the attitudes of the confederate (Zitek & Hebl, 2007). These results support the notion that in the absence of a clear social norm, people may find themselves looking to others to judge what behavior is socially acceptable (more susceptible to social influence).

The aforementioned study conducted by Zitek and Hebl (2007) incorporated five different stigmas which varied in the clarity of social norms toward the public display of prejudice. However, this study did not include data on mental health diagnoses. As of yet, no research seems to have explored the clarity of social norms around mental health and the social acceptability surrounding public displays of prejudice. Concerning mental health stigma in the workplace, it would be important to recognize the social norms present among employees and work to promote positive social norms, which would hopefully facilitate contact and reduce

stigma, as well as establish a very clear social norm that the public display of stigma towards individuals with psychological disorders is not socially acceptable.

Proposed Model: The Interaction of Familiarity, Attitudes, and Social Norms/Influence in the Workplace

Summary of Findings

The previous section outlined the research findings associated with three major social psychological mechanisms/constructs: familiarity, attitudes, and social norms/influence. Concerning familiarity, schemas (i.e., unconscious mental structures) were identified as being formed based on an individual's level of familiarity (i.e., knowledge and personal experience). Schemas for those with less familiarity are considered biased since they are often formed based on (mis)information from stereotypical media portrayals of individuals with psychological disorders. Conversely, schemas for those with more familiarity are considered informed since they are formed based on more accurate information from education/personal experience with mental health. Familiarity is inversely related to social distance and perceived dangerousness. The more familiar an individual is with mental health diagnoses, the less social distance and perceived dangerousness (less public stigma). The less familiar an individual is with mental health diagnoses, the more social distance and perceived dangerousness (more public stigma).

Moreover, attitudes can be divided into strong attitudes and weak/ambivalent attitudes. Strong attitudes are associated with greater resistance to change via persuasion or other social influence, while weak/ambivalent attitudes are associated with less resistance to change (more susceptible to attitude change). Further, attitude strength outcomes are correlated with attitude attributes such as ambivalence and certainty. Less ambivalent attitudes are more predictive of behavior and resistant to persuasion. Meanwhile, more ambivalent attitudes are less resistant

(more susceptible) to persuasion. Regarding certainty, more certain attitudes are typically considered to be stronger attitudes because they are characterized by information which is accurate and easily processed as well as more resistant to change via persuasion and more predictive of behavior. Conversely, less certain attitudes are less resistant to change and less predictive of behavior.

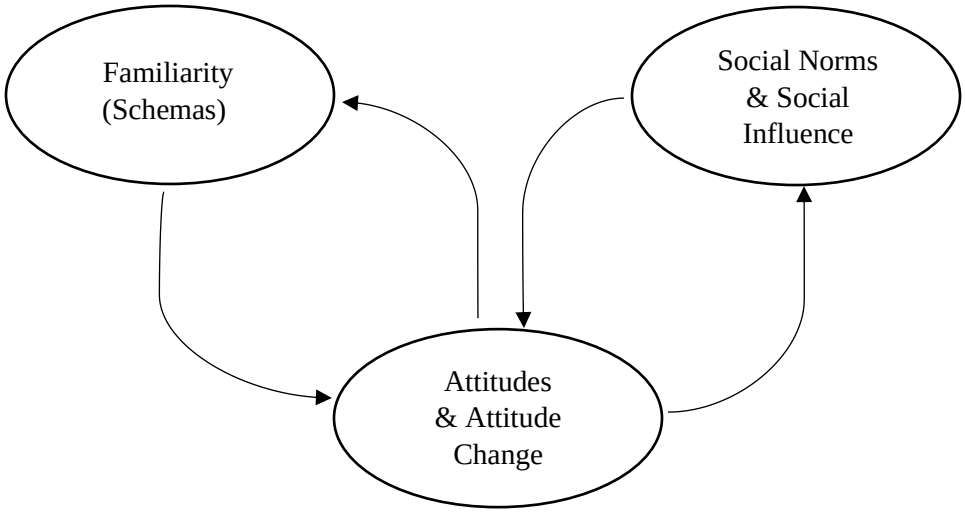
Social norms and social influence were also explored for their effects on behavior toward stigmatized groups, such as individuals with psychological disorders. Perceived social norms (injunctive and descriptive) have been shown to influence subsequent behavior. Specifically, positive social norms (also known as "improved norms") can decrease social distance through increased contact. Social influence (informational and normative) has the ability to guide the behavior of individuals. The more ambiguity that is associated with a particular situation, the more likely that individuals will conform to the views of others. Furthermore, the extent to which individuals will be susceptible to social influence can be predicted by the clarity of relevant social norms. Social norms that are clear (more widely known) should predict less susceptibility to social influence. Conversely, ambiguous social norms (less widely known) should predict more susceptibility to social influence.

Two different methods for attitude change were discussed. The first method is affective-cognitive matching, a strategy that aims to achieve attitude change through persuasion by targeting either emotions or beliefs, depending on the characteristics of the existing attitude. For affective-cognitive matching to work, an individual's attitudes must be ambivalent and low in certainty. Individuals low in familiarity would be more likely to have attitudes that are ambivalent. The second method is improved norms, a strategy that aims to change attitudes by changing social norms. Improved norms are positive social norms which facilitate positive direct

contact. Positive direct contact reduces negative emotions toward outgroup members and, ultimately, reduces stigma.

Proposed Model

The evidence provided by prior research into familiarity, attitudes (and attitude change), and social norms/influence can be consolidated into a cohesive model.



According to the model, individuals' level of familiarity (and concomitant schema formation) leads to the creation of attitudes. These attitudes then determine level of susceptibility to the effects of social norms and social influence. From there, the influence of these effects that do/do not occur informs the reassessment of attitude and possible attitude change. As attitudes change, levels of familiarity as well as the content of schemas may change.

For example, an individual who is less familiar with mental health diagnoses may form their schemas based on information from media sources, which tend to perpetuate negative stereotypes. This individual may form ambivalent attitudes toward mental health, as they may have mixed information from media sources that cause them to make both positive and negative

evaluations about mental health diagnoses simultaneously. Since they have ambivalent attitudes, they should be more susceptible to attitude change through persuasion or other social influences. Also, since they have a mix of both positive and negative information in their schemas, they may feel more uncertain of their ambivalent attitude toward mental health diagnoses. The combination of ambivalent attitudes with low certainty will predict less resistance (more susceptibility) to change. If this individual is then exposed to improved norms about mental health diagnoses, which facilitate positive direct contact, the stigma they harbor toward those with diagnoses may decline. The reduced levels of stigma, increased contact with individuals with mental health diagnoses, and influence of positive social norms can lead to the individual reappraising their attitudes. Their attitudes may thus change from ambivalent attitudes to more univalent, leaning more towards a positive attitude toward individuals with mental health diagnoses. This new attitude, as well as the increased direct contact, adjusts the individual's schema to a more positive outlook on mental health and raises their level of familiarity. This cycle continues as the individual continues taking in information, appraising it, and adjusting schemas, attitudes, and behaviors.

The circumstances outlined in this example would be particularly likely to happen in a workplace with low rates of disclosure, since recognized contact with individuals with psychological disorders would be low. A workplace environment that provides little to no exposure to mental health diagnoses, either through workplace trainings or the disclosure of co-workers/superiors, can do little to combat the information with which individuals form their schemas (e.g., negative stereotypical media portrayals). However, when a workplace takes the initiative to incorporate improved norms about mental health diagnoses into their trainings and/or general environment, they take a step towards fostering an environment of inclusion and

acceptance. It is through the implementation of stigma reduction strategies at either the attitudes (e.g., affective-cognitive matching) or social norm/influence (improved norms) steps of the model that ambivalent and uncertain attitudes can begin to transform into strong and certain attitudes about individuals with psychological disorders.

Testing the Model

To test the factors posited by the present theoretical framework and assess their potential influence in the workplace environment, we propose the methodology for a preliminary study investigating the relative impacts of familiarity, priming, and social influence on stigma towards individuals with psychological disorders in a simulated workplace context. Specifically, the questions under investigation are: (1) How and to what extent are participants' attitudes toward individuals with psychological disorders impacted by social influence and priming in a simulated workplace environment, and (2) Is this mediated or moderated by their level of personal familiarity/experience with mental health diagnoses?

This study will employ a within-subjects, quasi-experimental design with two independent variables (e.g., level of familiarity, group assignment) and repeated measures to assess the influence of familiarity on initial attitudes, as well as its impact on susceptibility to a priming/social influence manipulation. Participants will be randomly assigned to one of four groups (three experimental, one control). Each group will complete an initial questionnaire containing demographic and baseline questions assessing both level of familiarity with mental health diagnosis and attitudes toward individuals with psychological disorders (see next section for further details on these measures and refer to Appendices A and B for example items). Participants in each of the three experimental groups will then read a short story meant to prime them to perceive individuals with psychological disorders in a positive, negative, or neutral way

via social influence, by presenting workplace scenarios in which an individual's disclosure is met with a positive, negative, or neutral response from co-workers, while participants in a control group read a similar workplace scenario that omits any reference to mental health (see Appendix C).

All participants will then complete the attitudinal assessments for a second time. Comparing participants' pre- and post-manipulation attitudes will allow us to assess whether and to what extent priming and social influence can affect an individual's tendency to endorse public stigma toward individuals with psychological disorders. Moreover, by assessing individuals' level of familiarity with psychological disorders and attitudes prior to the experimental manipulation, we will be able to further examine whether and how an individual's level of familiarity (and thus their schemas) and pre-existing attitudes might affect their susceptibility to social influence in the workplace. When individuals with low levels of familiarity also have weak/ambivalent attitudes, they may rely on others' behaviors to infer what to do in an unfamiliar or ambiguous situation. In other words, they conform to informational social influence. Within the context of this study, people with low levels of familiarity with mental health diagnoses, particularly in terms of the disclosure situations presented in the short story, may be more likely to rely on the reactions of others to infer the "correct" response.

Data collection is ongoing, but it is hypothesized that individuals with low levels of familiarity will be expected to have weak/ambivalent attitudes. Consequently, when introduced to the priming stimulus, they will be susceptible to social influence. When introduced to the attitudinal assessment for the second time (post-test), they will undergo an attitude change and express the attitudes for which they were primed. On the other hand, individuals with high levels

of familiarity will be expected to have strong attitudes. As a result, they will not be susceptible to the priming stimulus and will not undergo an attitude change.

Proposed Measures and Their Connections to the Theoretical Framework

Questions from the following measures will be included in this questionnaire: Level of Contact Report (Holmes et al., 1999) and Community Attitudes Toward Mental Illness (CAMI) scale (Taylor & Dear, 1981). Both are established measures which have demonstrated good reliability and validity. As the measures are right now, they include terminology which is not politically correct in today's day and age. The questions included in the questionnaire will all be adapted versions of the current questions with more politically correct terminology. For example, one of the questions from the CAMI scale states: "There is something about the mentally ill that makes it easy to tell them from normal people." This question will be rephrased as "Individuals with psychological disorders are easily distinguishable from people without psychological disorders." In the present questionnaire, only the adapted versions of both the Level of Contact Report (see Appendix A) and CAMI scale (see Appendix B) will be utilized.

Demographic Questions (Familiarity Items; Appendix A). The demographic questions will include the Level of Contact Report (Holmes et al., 1999), a measure developed to assess level of familiarity with mental health diagnoses. The measure lists 12 situations that represent varying levels of familiarity. The rank order of these situations was determined by three experts in the field of "psychiatric disability" and validated by a sample of 100 research participants (Holmes et al., 1999). Relative levels of familiarity will be divided into "least familiarity," "medium familiarity," and "high familiarity." On the questionnaire, participants will be instructed to check off all the situations that they have experienced over their lifetime. An individual's level of familiarity will be determined by the rank score of the highest familiarity

situation that they checked off. For example, a participant who checked off three situations with rank scores of 4, 7, and 9 would receive a score of 9.

This measure of familiarity connects to the theoretical framework in that it can tell us an individual's personal level of familiarity with mental health diagnoses. As we already know, familiarity has an inverse relationship with social distance. As a result, an individual that has a low level of familiarity will be expected to be more likely to engage in public stigma towards those with psychological disorders. Unfortunately, this measure cannot tell us what information individuals used to form their schemas about mental health diagnoses. For this preliminary study, we will have to assume that individuals with low levels of familiarity have formed their schemas (if they have formed any at all) based upon misinformation from the media. To that point, we will have to assume that individuals with high levels of familiarity have formed their schemas based on personal experiences interacting with those with psychological disorders (or even having one themselves).

Baseline and Follow-Up Questions (Attitude Measures; Appendix B). The baseline as well as the follow-up questions will come from the 40-item Community Attitudes Toward Mental Illness (CAMI) scale (Taylor & Dear, 1981), an established reliable and valid measure of individuals' explicit attitudes towards those with psychological disorders. The presentation of items will be randomized, as this measure will serve as a pre-test and post-test for the assessment of attitudes toward individuals with psychological disorders. The pre-test will document the initial attitudes of participants toward individuals with psychological disorders, and the post-test will determine participants' attitudes after interacting with the priming stimulus (the control group will not have been primed). Given the length of the CAMI scale, it will be condensed to 30 items, especially since it will be utilized twice.

This measure of familiarity connects to the theoretical framework in that participants' responses to the pre-test (initial assessment of attitudes) questions can reveal whether an individual has a pre-existing prejudice towards those with mental health diagnoses. In addition, the assessment of attitudes at two different time points (pre-test and post-test) allows us to assess for any attitude change. Unfortunately, this measure cannot inform us of the strength of participants' attitudes based on levels of ambivalence or certainty. For this preliminary study, we will have to assume that participants who do not express a change of attitude between the pre- and post-test must have strong attitudes (more resistant to change). Conversely, participants that do express a change of attitude between the pre- and post-test must have more ambivalent attitudes (susceptible to persuasion).

Short Story Portion (Social Influence Prime; Appendix C). After the baseline, but before the follow-up questions, will be the short story, which will be slightly different for each of the four different groups. The control group's questionnaire will include a short story that is unrelated to mental health, but rather, related to general interactions in a workplace environment. As for the experimental groups, the stories provided will act as a priming stimulus to simulate social influence. The main story, common across all three experimental groups, will be about an individual who decides to self-disclose their psychiatric diagnosis to their coworkers and superiors. However, the stories will diverge as the individual witnesses their coworkers' and superiors' reactions to their announcement. The three variations across the experimental groups will be: positive, negative, and neutral reactions.

This priming stimulus connects to the theoretical framework in that it can determine the susceptibility of participants to social influence based upon their level of familiarity and the strength of their attitudes. As we already know, individuals with weak/ambivalent attitudes are

more susceptible to social influence. The expectation is that individuals with low levels of familiarity will have weak/ambivalent attitudes and be more susceptible to the influence of the priming stimulus. If an individual has been influenced by the priming stimulus, it should show in their pre- and post-test results as a significant change in attitude. For example, an individual's responses may suggest that they harbor negative initial attitudes towards those with psychological disorders. After exposure to the short story which details positive reactions to mental health, their post-test responses are less negative. Unfortunately, if someone has a pre-existing prejudice, it may take more than a brief online simulation of social influence to make a noticeable impact on their attitudes. Moreover, because participants are randomly assigned to groups, they may receive the neutral or negative prime. For a participant with a pre-existing prejudice, this would lead to less likelihood of attitude change (or a strengthening of their initial negative attitude).

Conclusions

If the proposed theoretical framework and our associated hypotheses regarding the interactions among familiarity, attitudes, and social norms/influence are supported, then some potential strategies for improving workplace conditions may lie in strategic persuasion, social influence, and changing social norms. Research supporting affective-cognitive matching provides the promise of workplace trainings which employ persuasion to strategically change minds for the better by directly targeting attitudes. Furthermore, research on susceptibility to social influence and social norms reveal what conditions (e.g., familiarity, attitude strength) must be met to successfully influence individuals. For example, if individuals are faced with an unfamiliar or ambiguous situation concerning mental health at work, they may look to others for guidance on their behavior (informational social influence). If one's co-workers act favorably

toward mental health in that situation, those who initially sought guidance may be more inclined to act favorably toward mental health in the future. As for social norms, research on improved norms (positive social norms) have demonstrated their ability to increase contact and reduce stigma.

Workplace trainings could potentially incorporate these strategies in a few different ways. For example, affective-cognitive matching and improved social norms could be employed in compliance training courses which provide education on mental health diagnoses and encourage positive social interactions with and perceptions of those with diagnoses. Throughout such a course, individuals might be exposed to empirically backed facts and figures (cognitive matching) about mental health diagnoses as well as videos featuring hypothetical workplace scenarios which involve interactions between co-workers (affective matching). These workplace scenarios could ascribe humanity to those with diagnoses and dispel any negative stereotypes (e.g., dangerousness) towards mental health diagnoses. The aforementioned videos could also communicate improved social norms by demonstrating how employees should act (injunctive norms) towards individuals with psychological disorders in the workplace.

If workplaces begin to employ the above strategies in workplace trainings, the acceptance of mental health may increase in the workplace. This acceptance would imply a decrease in public stigma and social distancing, creating a welcoming environment for individuals with psychological disorders. As mentioned before, many individuals with psychological disorders are hesitant to disclose their mental health diagnoses to co-workers and superiors. This is because they expect to be social rejected by others due to perceived and/or actual public and self-stigma. The employment of these strategies as a method for reducing actual public stigma in the

workplace would hopefully create an environment where individuals with psychological disorders felt comfortable disclosing if they wanted to.

Future Directions

If our initial hypotheses are supported, future research based on the proposed theoretical framework should seek to build on the findings of this preliminary study. For example, instead of an online questionnaire, a future study could have individuals participate in person. In an in-person experimental design, experimenters could first assess for participants' levels of familiarity and initial attitudes, and then assign them to groups to ensure that participants will always have the opportunity for attitude change (excluding the control group). An in-person study would provide options for experimental design. One design may mirror our preliminary study and have individuals take questionnaires by themselves or with other participants (or even confederates) in the room. Another design may have participants interacting with a single individual or a group of individuals in a situation where an individual with a psychological disorder (a confederate) discloses their disorder. In essence, this design would have participants acting out one of the four vignettes in real life.

In addition, future studies could utilize measures which determine the source of individuals' information (inform the formation of their schemas) as well as assess for levels of ambivalence and certainty of attitudes. The employment of such measures would allow experimenters to investigate the relationship between ambivalence and certainty in predicting the susceptibility of participants to persuasion. This relationship could be explored through affective-cognitive matching. For example, one study could determine the source of participants' attitudes, then assess for the ambivalence and certainty these attitudes. After collecting this information,

participants would be sorted into one of two experimental groups: 1) affectively based persuasion, and 2) cognitively based persuasion.

Under the guise of a pilot workplace training on diversity, equity, and inclusion, participants would be exposed to either an affective or cognitive argument for the acceptance of individuals with psychological disorders in the workplace environment. According to the research on affective-cognitive matching, it would be expected that individuals with more affectively based attitudes would express more positive attitudes toward mental health after hearing the affective argument (Tormala & Rucker, 2017). Conversely, participants with more cognitively based attitudes would express more positive attitudes toward mental health after hearing the cognitive argument (Tormala & Rucker, 2017). Participants with an affectively based attitude would not be affected by a cognitive argument, and vice versa. The findings of this study could inform the development of workplace trainings which reduce stigma through strategic persuasion.

A limitation acknowledged in the research by Zitek and Hebl (2007) was their inability to make definitive conclusions about whether the effects on participants' attitudes were driven by normative social influence, informational social influence, or a combination of the two. Future research could investigate whether both types or only a single type of social influence is capable of causing attitude change. To that point, it would be interesting to explore the interaction between familiarity, attitudes, and both types of social influence. It would stand to reason that those individuals with low levels of familiarity and weak/ambivalent attitudes would be more susceptible to both types of social influence. Conversely, individuals with high levels of familiarity and strong attitudes would not be susceptible to either type of social influence.

Although, whether normative social influence or informational social influence was more salient would depend upon the construction of the experimental situation.

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Appendix A. The Level of Contact Report

Please read each of the following statements carefully. After you have read all the statements below, check off all the situations which you have experienced over your lifetime. (**Author's Note:** Rankings made by the panel of experts are included for each item but will not be listed in this experiment's finalized questionnaire. To assist with the voluntary nature of participation and to help alleviate the potential stress of certain questions, there is a "I prefer not to say" answer option.)

- I have watched a movie or television show in which a character depicted a person who has a psychological disorder.
    - Rank score: 3
- My current job involves providing services and/or treatments for people with psychological disorders.
    - Rank score: 8
- I have seen, in passing, a person I believe may have had a psychological disorder.
    - Rank score: 2
- I have seen people with psychological disorders on a frequent basis.
    - Rank score: 5
- I have a psychological disorder.
    - Rank score: 12
- I have worked with a person who has a psychological disorder at my place of employment.
    - Rank score: 6

- I have never seen a person that I was aware had a psychological disorder.
    - Rank score: 1
- My current job involves providing services to people with psychological disorders, not including treatments.
    - Rank score: 7
- A friend of the family has a psychological disorder.
    - Rank score: 9
- I have a relative who has a psychological disorder.
    - Rank score: 10
- I have watched a documentary on television about psychological disorders.
    - Rank score: 4
- I currently live with a person who has a psychological disorder.
    - Rank score 11
- I prefer not to say.

Appendix B. Community Attitudes Toward Mental Illness (CAMI) Scale

The following statements express various opinions about mental health problems and those with psychological disorders. Psychological disorders are a wide range of conditions that affect mood, thinking, and behavior. Individuals with psychological disorders have received a clinical diagnosis for which they require treatment and are capable of independent living outside a hospital. Please indicate the response which most accurately describes your reaction to each statement. It is your first reaction which is important. Do not be concerned if some statements seem similar to ones you have previously answered. Please be sure to answer all statements.

(**Author's Note:** Participants will be asked to rate how much they agree or disagree with each statement listed below. The rating options range from strongly agree to strongly disagree. To assist with the voluntary nature of participation and to help alleviate the potential stress of certain questions, there is a "Not Applicable" answer option.)

Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree, Not Applicable

1) As soon as a person shows signs of a mental health problem, they should be hospitalized.
2) Individuals with psychological disorders should be isolated from the rest of the community.
3) Individuals with psychological disorders are easily distinguishable from people without psychological disorders.
4) I would not want to live next door to someone with a psychological disorder.
5) Anyone with a history of mental health problems should be excluded from taking public office.

6) One of the main causes of mental health problems is a lack of self-discipline and will power.
7) Less emphasis should be placed on protecting the public from individuals with psychological disorders.
8) No one has the right to exclude individuals with psychological disorders from their neighborhood.
9) Individuals with psychological disorders should not be treated as outcasts of society.
10) Individuals with psychological disorders should be encouraged to assume the responsibilities of everyday life.
11) A mental health problem is no different than a physical health problem.
12) Individuals with psychological disorders are far less of a danger than most people assume.
13) Psychiatric hospitals are an outdated means of treating individuals with psychological disorders.
14) Individuals with psychological disorders should not be denied their individual rights.
15) Virtually anyone can develop a mental health problem.
16) More tax money should be spent on the care and treatment of individuals with psychological disorders.
17) The best therapy for many individuals with psychological disorders is to be included by the community they live in.
18) Individuals with psychological disorders have been the subjects of ridicule for too long.
19) We need to adopt a far more tolerant attitude toward individuals with psychological disorders in our society.

20) Psychiatric hospitals seem more like prisons than like places where individuals with psychological disorders can be cared for.
21) Locating mental health services in residential neighborhoods does not endanger local residents.
22) We have the responsibility to provide the best possible care for individuals with psychological disorders.
23) Residents have nothing to fear from people coming into their neighborhood to obtain mental health services.
24) Increased spending on mental health services is a waste of tax dollars.
25) Having individuals with psychological disorders living within residential neighborhoods might be good therapy, but the risks to residents are too great.
26) There are sufficient existing services for individuals with psychological disorders.
27) Individuals with psychological disorders are a burden on society.
28) Locating mental health facilities in a residential area downgrades the neighborhood.
29) Individuals with psychological disorders do not deserve our sympathy.
30) Mental health facilities should be kept out of residential neighborhoods.

Appendix C. Original Short Stories

Control Group

Imagine that you're an office worker. You've been working at this office for 5 years and know all your coworkers very well. It's just a regular workday and you're sitting at your desk. Everyone's lunch break is coming to an end, so each of your coworkers is slowly returning to their desks. Just as everyone seems settled in to continue the workday, your coworker Adrian stands up and makes their way to the center of the room. They announce, "Hello, everyone. I have an announcement that I would like to make. I know I've only worked at this company for roughly 2 years, but I feel like I've come to know each and every one of you. As a result, I would like to invite you all to my home for a barbecue next Friday. The weather promises to be beautiful, so I thought that it would be nice to take advantage of the weather and use this opportunity to further solidify the bonds we have here at the office." They pause to wait for a reaction from their peers. Scanning the room, you notice a range of expressions and reactions. Some people have smiles on their faces, seemingly excited at the idea of a barbecue. Others are gazing down at their cell phones or computers, most likely checking their calendars to see if they can attend. One of your coworkers stands up and smiles, "I think this barbecue is a wonderful idea. Why don't we make it a potluck, so we can all contribute? I'll bring a fruit salad."

Experimental Group – Negative

Imagine that you're an office worker. You've been working at this office for 5 years and know all your coworkers very well. It's just a regular workday and you're sitting at your desk. Everyone's lunch break is coming to an end, so each of your coworkers is slowly returning to their desks. Just as everyone seems settled in to continue the workday, your coworker Adrian stands up and makes their way to the center of the room. They announce, "Hello, everyone. I

have an announcement that I would like to make. I know I've only worked at this company for roughly 2 years, but I feel like I've come to know each and every one of you. I realize that a cohesive workplace environment is built off trust, so I would like to trust you all now. A few years ago, I was diagnosed with schizophrenia…" Several gasps can suddenly be heard throughout the room. Scanning the room, you notice a range of expressions and reactions. Some people seem surprised and even scared, with wide eyes and their hands covering their mouths. Other's mouths have turned down in what seems like a mix of disapproval and disgust. And still others seem angry. One of your coworkers stands up, gritting their teeth and saying, "Are you kidding!? We've worked with you for how long and you're only telling us this now?"

Experimental Group – Neutral

Imagine that you're an office worker. You've been working at this office for 5 years and know all your coworkers very well. It's just a regular workday and you're sitting at your desk. Everyone's lunch break is coming to an end, so each of your coworkers is slowly returning to their desks. Just as everyone seems settled in to continue the workday, your coworker Adrian stands up and makes their way to the center of the room. They announce, "Hello, everyone. I have an announcement that I would like to make. I know I've only worked at this company for roughly 2 years, but I feel like I've come to know each and every one of you. I realize that a cohesive workplace environment is built off trust, so I would like to trust you all now. A few years ago, I was diagnosed with schizophrenia…" They pause to wait for a reaction from their peers, but no one comments. Scanning the room, you notice that people's faces exhibit fairly neutral expressions. Almost everyone has either a blank or confused expression. One of your coworkers stands up and says, "Honestly, I don't know very much about schizophrenia, so I

can't offer much of an opinion on the matter. All I can say is that I appreciate you trusting us with this information, Adrian."

Experimental Group – Positive

Imagine that you're an office worker. You've been working at this office for 5 years and know all your coworkers very well. It's just a regular workday and you're sitting at your desk. Everyone's lunch break is coming to an end, so each of your coworkers is slowly returning to their desks. Just as everyone seems settled in to continue the workday, your coworker Adrian stands up and makes their way to the center of the room. They announce, "Hello, everyone. I have an announcement that I would like to make. I know I've only worked at this company for roughly 2 years, but I feel like I've come to know each and every one of you. I realize that a cohesive workplace environment is built off trust, so I would like to trust you all now. A few years ago, I was diagnosed with schizophrenia…" They pause to wait for a reaction from their peers. Scanning the room, you notice a range of expressions and reactions. Some people have smiles on their faces, a gesture which seems to communicate encouragement and support. Others give Adrian nods of approval for their candor. One of your coworkers stands up, walks to the center of the room to meet Adrian, and puts a hand on their shoulder. With a smile, they tell Adrian, "Thank you for trusting us with this information. I hope you know that we are all here to support you in any way that we can."