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Emily Raduns

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ABSTRACT

Background

Mental health stigma describes the prejudice and discrimination faced by those with mental health disorders. Existing literature has connected heightened levels of stigma to lower levels of mental health education and lower levels of interpersonal contact with those experiencing mental health issues. Research also suggests a possible link between high religious fundamentalism and stigma.

Methods

To assess relationships among these variables, a questionnaire was distributed online to 194 undergraduate students at a small religious university in the Midwest. The questionnaire included scales measuring fundamentalism and stigma, along with questions about mental health education levels and interpersonal contact with those experiencing mental health issues. Participants were recruited through professors known by the researcher, who e-mailed a link to the survey to their classes. Informed consent was given before participants continued to the rest of the survey.

Results

Data were analyzed using correlational tests and t-tests, and no statistically significant relationships were found between stigma and fundamentalism, contact, or education.

Conclusion

The lack of statistical significance suggests that the anticipated relationships did not exist in the sample surveyed. However, the scale used to assess stigma also has questionable validity, as demonstrated in the most recent research in which it has been used. Therefore, it is difficult to draw weighty conclusions from the study.

LITERATURE REVIEW

Empirical Correlates of Mental Health Stigma

Mental health stigma is the phenomenon of prejudice and discrimination placed on those who have experienced or are currently experiencing a psychological disorder (Phelan, Link, and Dovidio, 2008). This stigma impacts many areas of life for those experiencing mental health issues, as discussed in the meta-analysis of Sickel, Seacat, and Nabors (2014). Research has connected stigma to lower levels of self-esteem, discrimination in employment and housing, difficulties in interpersonal relationships, and negative physical health outcomes. These factors can contribute to increased mental health symptoms and reduced coping methods, while discouraging treatment seeking and compliance.

Several authors have developed theories on the origin and continuation of stigma. An early pioneer in the field was the sociologist Erving Goffman (1963), who wrote that stigma arises from incongruencies between a person's expected and actual attributes. His work provides the foundation on which all other stigma research has been built,

including the following modern theorizations of the term. Corrigan's conceptualization (2000) is based in attribution theory and is centered on the controllability and stability perceived within mental disorders. His research suggests that increased levels of perceived stability or controllability at either onset or offset of illness are related to increased levels of stigma. Link and Phelan (2001) propose a theory that focuses on a combination of labeling, ingroups and outgroups, and power differentials leading to prejudice and discriminatory actions. The combination of these theories, particularly Corrigan's and Link's, form a strong theoretical basis for understanding stigma and the backbone of much of modern research in the field.

Religious Fundamentalism

One variable worthy of analysis involves the role of religious beliefs in mental health stigma. Very little research has been devoted to this specific relationship, but there is a wealth of research connecting religious fundamentalism to other stereotypes and prejudices, with a specific focus on Christian fundamentalism due to the religion's prominence within the United States (Johnson et al., 2011; Rowatt, Kelly, LaMartina, McCullers, and McKinley, 2006). Through a careful analysis of prominent conceptualizations of stigma and prejudice, Phelan et al. (2008) established that the two concepts overlap greatly and are used to describe and study the same phenomenon. This allows researchers to form a conceptual link between existing theory on the prejudice associated with religiosity and stigma.

In order to understand this connection, the elements of religiosity that contribute to prejudice must first be established. Johnson et al. (2011) conducted a correlational study analyzing the relationships between racial and sexual orientation-based prejudices and religious authoritarianism and fundamentalism. A questionnaire was administered to 289 college students with scales of religious fundamentalism, authoritarianism, racial prejudice, and attitudes toward men and women in same-sex relationships. The results demonstrate that fundamentalism is associated with higher levels of value-violating prejudices, or prejudices against things that violate Christian values, such as those toward homosexuality ($r = 0.63, p < 0.001$). Authoritarianism is associated with higher levels of racial prejudice ($r = 0.27, p < 0.001$ for the aggression subscale). The authors suggest that this implicates religious fundamentalism, which they define as "a close-minded set of beliefs contingent upon one fundamental inerrant set of teachings about humanity and the deity" (p. 851), as a likely correlate of mental health stigma, as mental illness is categorized as value-violating as well.

Altemeyer (2003) surveyed 837 college students and 1,308 of their parents, finding a strong correlation between religious ethnocentrism and religious fundamentalism. Altemeyer states that this correlation suggests that individuals high in religious fundamentalism will express a greater tendency toward conceptualizing others as part of an outgroup on the grounds of religion, as other studies have shown those high in religious ethnocentrism to do. He argues that the emphasis that religious fundamentalism places on being a member of a religious organization provides the basis for an "us versus them" mindset. This allows individuals who differ in ways

other than religion to be placed more easily into outgroups and to consequently face prejudice. The often-religious perception of high onset and offset controllability of mental illness, along with this tendency toward outgroup formation, suggests that stigma is likely to follow.

The first to analyze the fundamentalism-stigma link outside of the context of pastoral ministry were Wesselmann and Graziana (2010). They conducted a correlational study on the connection between religiosity and mental health stigma. The study was conducted using a questionnaire with an informal scale to identify the prejudices commonly held among religious college students and previously validated scales to assess religious fundamentalism and orthodoxy. Fundamentalism was linked to more strongly held prejudices and negative beliefs about mental illness. Participants were also asked whether they have had exposure to individuals with mental disorders. Having close contact with an individual with a mental illness lessened the effects of fundamentalism on stigma. Essentially, the authors found that high religious fundamentalism was connected to a higher level of stigma.

Research in the connection between religious fundamentalism and mental health stigma is sparse but does suggest that such a connection does exist. This led to this study's Hypothesis 1, which improves on Wesselmann and Graziana (2010) by measuring stigma with a validated scale. H1: *Mental health stigma and religious fundamentalism will be positively correlated.*

Intergroup Contact Theory

According to the meta-analysis conducted by Pettigrew, Tropp, Wagener, and Christ (2011), intergroup contact theory states that contact between different groups results in lower levels of prejudice. The theory originated in the wake of the Civil Rights movements, when racial tensions were eased in individuals that had contact with others of a different race. Some research operates on the assumption that contact requires four positive features to effectively reduce prejudice: equal status between groups, common goals, intergroup cooperation, and the support of authority. Recent research and meta-analysis has supported the effect of these factors but demonstrated that they are not necessary for attitude change. With or without these optimal factors, the increase in knowledge and empathy for the group and the decrease in anxiety associated with intergroup contact contributes to a negative correlation between contact and prejudice.

In 2013, Aggarwall, Thompson, Falik, Shaw, O'Sullivan, and Lowenstein initiated and evaluated a mental health education program for first-year medical school students. The program consisted of a panel of four to six students sharing their personal experiences with mental illness for one hour, followed by a small group discussion for another hour. The students who participated in the program showed decreases in social distancing and increases in willingness to disclose personal struggles from pre-test to post-test ($p < 0.01$), suggesting a reduction in stigma.

Bizub and Davidson (2011) completed a qualitative study of the effects of the completion of a program called Compeer, in which individuals with mental illness are paired with community volunteers to foster friendship. The student participants, all senior psychology majors, were simply asked to describe their thoughts going into the program and their thoughts on the friendship that was formed. Major themes include anxiety about the program prior to its beginning, with roots in a sense of dangerousness and unpredictability of those with mental illnesses. Empathy and greater understanding were more prevalent at the completion of the program, stemming from the friendship that was formed.

Studies on contact often fail to assess the relationship between everyday, casual contact and stigma. To address this gap, this study assesses this kind of casual contact. This, along with the existing research on intergroup contact theory, leads to Hypothesis 2. H2: *Individuals with higher levels of contact with individuals experiencing mental health issues will report lower levels of mental health stigma than individuals with lower levels of contact.*

Education

Many researchers investigating mental health stigma are primarily concerned with stigma among those who work professionally with individuals experiencing these disorders. As such, a great deal of research has centered on the assessment and reduction of stigma among mental health professionals and other professionals who are likely to encounter mental health issues, such as medical professionals. This area of research has also been extended to students intending to enter these fields, in the hopes that intervention while in training can reduce potential harm while in practice.

Emul et al. (2011) conducted a quasi-experiment studying the stigmatization of suicide attempters among medical and non-medical students at a Turkish school. Students completed a questionnaire that measured prejudices. Most comparisons between medical and non-medical students were not statistically significant. Comparisons that were significant seem to demonstrate that the medical students hold lower levels of stigma than the non-medical students and that medical students in clinicals have lower levels of stigma than those that are in earlier stages of the program. These differences, however, were only demonstrated on select questionnaire items and were relatively small.

Zellmann, Madden, and Aguiniga (2014) conducted a study with a school's social work department, using a survey devised by the authors. They found that many students believed that social work in mental health is not rewarding. Using a cross-section of students in various class levels, those at higher class levels were more likely to believe that meaningful goals and successful careers are not accomplishable for individuals with mental illnesses. The results of the study are concerning but very limited. The scale was devised by the authors and has no tested reliability or validity, so the results may not reflect stigma itself but another related construct. Additionally, it may be true that mental health work can at times be unrewarding, but the authors were quite concerned about this belief among their students.

Smith and Cashwell (2010) used a questionnaire to gather data on and analyze the authoritarianism, benevolence, social restrictiveness, and community mental health ideology of 188 graduate students and professionals in the mental health field in comparison with those not in the mental health field. Results indicated that those in the mental health field have lower levels of authoritarianism and social restrictiveness with higher levels of benevolence and community mental health ideology (all p 's < 0.05). Essentially, in this study mental health workers and students did in fact display lower levels of stigma than non-mental health workers and students.

Research on the attitudes of students often focuses on one area of study, instead of assessing various areas or even comparing different groups entering the mental health field. Additionally, comparing students who have and have not taken mental health-related courses could assess their impact on stigma. This, along with the conclusion of most existing research, leads to this study's Hypothesis 3. H3: *Individuals with higher levels of education on mental health will report lower levels of mental health stigma than those with lower levels of education.*

METHODS

Participants

The participants included 194 undergraduate students at a small religious university in the Midwestern United States recruited through general education and social work courses. The average age of the students was just over twenty, and most students were between the ages of eighteen and twenty-two. Females accounted for 144 of the 194 responses. Of the participants, 84% identified as White, 3% identified as Black or African American, and 3.5% identified as Hispanic, Latino, or Spanish origin.

Sixteen students reported not knowing anyone experiencing mental health issues, thirty-four reported knowing someone but not well, eighty-seven reporting knowing someone well, and fifty-eight reported experiencing mental health issues themselves. Thirty-five participants were majoring in social work, thirty-one were majoring in psychology, and 128 were majoring in other areas. Most participants had taken none of mental health-related courses offered at the university, twenty-four had taken one of the courses, three had taken two of the courses, and two had taken three.

Materials

Stigma was assessed using the Perceived Devaluation-Discrimination Scale (Link, Cullen, Frank, and Wozniak, 1987). The scale includes twelve statements accompanied by Likert scales with four points ranging from strongly agree to strongly disagree. Link et al. (1987) began statements with the phrase "most people would . . ." to reduce social desirability in responses. This occurs when participants select responses based on a desire to appear likable or good; the use of "most people" allowed participants to express their own views in a depersonalized way. (See Appendix A.) This scale had high internal consistency, with $\alpha = 0.84$.

Religious fundamentalism was assessed using the Revised Religious Fundamentalism Scale (Altemeyer and Huntsberger, 2004). The scale included another twelve statements and accompanying Likert scales with eight points ranging from very strongly disagree to very strongly agree. (See Appendix B.) Internal consistency was high, with $\alpha = 0.89$.

Contact was assessed through the question, "Have you known anyone personally experiencing mental health issues?" Responses included "no," "yes but I do not know them well," "yes and I do know them well," and "I have experienced these issues myself." Education was assessed using college major and the question, "Which of the following courses have you taken (or are you currently taking)?" Options included mental health-related courses in the social work, psychology, nursing, and theology departments.

Procedures

Participants received an email from various professors briefly describing the study and requesting their participation. Participants then followed a link to an online survey, where they read an informed consent page then selected "continue" to complete the rest of the survey. Some participants entered their names to receive extra credit in a course, and many entered their name to be placed in a drawing for one of two \$25 gift cards that were awarded as survey incentives. All data were de-identified immediately after gift card winner selection and before beginning data analysis using SPSS. Hypotheses were tested using correlational tests (H1), t-tests (H3 – college major), and ANOVAs (H2 and H3 – number of courses taken).

RESULTS

Students' mean score on the Perceived Devaluation-Discrimination Scale (Link et al., 1987) was 19.8, with a standard deviation of 4.7. The Revised Religious Fundamentalism Scale (Altemeyer and Huntsberger, 2004), which could produce a negative score, had a mean score of 9.3 and a standard deviation of 18.7.

There was no relationship between religious fundamentalism and mental health stigma, $r(195) = 0.06$, $p = 0.42$. This is inconsistent with the prediction in H1. There was also no relationship between interpersonal contact and mental health stigma, $F(4, 192) = 0.67$, $\eta^2 = 0.01$, and $p = 0.62$, which is inconsistent with the prediction in H2. Additionally, no relationship was found between education and mental health stigma when education was measured as the number of courses taken, $F(3, 192) = 1.03$, $\eta^2 = 0.01$, and $p = 0.38$, and by college major, $t(192) = -1.37$, $\eta^2 = 0.21$, and $p = 0.17$. Therefore, results from both operational definitions are inconsistent with H3.

DISCUSSION

This study assessed stigma and its relationship with several other variables among university students, finding no significant relationships between stigma, religious fundamentalism, contact, and education. This contradicts the research hypotheses and appears to contradict the existing literature on these topics or at least suggests that

relationships between these variables are less meaningful than other research suggests. The notable exception to this is in the relationship between fundamentalism and stigma, which has not been researched enough for generalized conclusions to be drawn.

However, this study is hindered by several limitations. The sample may not be representative of the general undergraduate population, which could be remedied through random selection. All data were obtained through self-report, which may not accurately represent student attitudes. There may be a sampling bias due to the recruiting methods used to obtain participants (through professors known by the researcher).

Additionally, the scale used to assess stigma may not be valid in measuring this variable. Further literature review suggests that the scale is being used to assess self-stigma in recent research (Cathoor, Schrijvers, Hutsebaut, Feenstra, and Sabbe, 2015; Martinez-Zambrano, Pizzimenti, Barbeito, Vila-Badia, Comellas, Escandell, ... Ochoa, 2016). The “most people . . .” phrasing, originally used to reduce social desirability bias, is now being used to measure the way those with mental health issues believe others perceive them. As such, measurement of this study’s dependent variable may be invalid, making it more difficult to draw conclusions from the results. The hypothesized relationships, therefore, may truly not exist in this population, or they may have been identified using a different, valid scale to measure stigma.

Future research in this area would benefit from different methods of assessing stigma levels. A different self-report scale could be used to address the possible invalidity of the Perceived Devaluation-Discrimination Scale (Link et al., 1987). Assessment not based in self-report could also eliminate social desirability response bias and provide strong, valid measurements of both stigma and religious fundamentalism.

Given the strong and negative consequences of mental health stigma, research identifying causes and correlates could lead to better outcomes for those experiencing mental health issues. If the relationships between contact, education, and stigma are in fact nonexistent or weak, there are strong implications for social work and psychology education. Students in these programs will ideally hold lower levels of stigma, since they are more likely to enter the mental health field and any level of stigma could negatively impact clients. If these lower levels are not demonstrated, stigma reduction methods should be considered and integrated into coursework. Although this study did not provide conclusive results, the implications for mental health care and education should be considered.

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APPENDIX A

Perceived Devaluation-Discrimination Scale - Each question will be accompanied by a scale from “Strongly disagree” to “Strongly agree.”

1. Most people would accept a person who has been in a mental hospital as a close friend.*
2. Most people believe that someone who has been hospitalized for mental illness is dangerous.
3. Most people believe that a person who has been hospitalized for a mental illness is just as trustworthy as the average citizen.*
4. Most people would accept a person who has fully recovered from mental illness as a teacher of young children in a public school.*
5. Most employers will not hire a person who has been hospitalized for mental illness.
6. Most people think less of a person after he/she has been hospitalized for a mental illness.
7. Most people would be willing to marry someone who has been a patient in a mental hospital.*
8. Most employers will hire a person who has been hospitalized for mental illness if he or she is qualified for the job.*

9. Most people believe that entering a psychiatric hospital is a sign of personal failure.
10. Most people will not hire a person who has been hospitalized or serious mental illness to take care of their children, even if he or she had been known well for some time.
11. Most people in my community would treat a person who has been hospitalized for mental illness just as they would treat anyone.*
12. Most young people would be reluctant to date someone who has been hospitalized for a serious mental illness.

*Reverse coded

APPENDIX B

Revised Religious Fundamentalism Scale - Each question will be accompanied by a scale from “Very strongly disagree” to “Very strongly agree.” You may find that you sometimes have different reactions to different parts of a statement. For example, you might very strongly disagree with one idea in a statement, but slightly agree with another idea in the same item. When this happens, please combine your reactions, and indicate how you feel on balance.

1. God has given humanity a complete, unyielding guide to happiness and salvation, which must totally be followed.
2. No single book of religious teachings contains all the intrinsic, fundamental truths about life.*
3. The basic cause of evil in the world is Satan, who is still constantly and ferociously fighting against God.
4. It is more important to be a good person than to believe in God and the right religion.*
5. There is a particular set of religious teachings in this world that are so true, you can't go any “deeper” because they are the basic, bedrock message that God has given humanity.
6. When you get right down to it, there are basically only two kinds of people in the world, the righteous, who will be rewarded by God; and the rest, who will not.
7. Scriptures may contain general truths, but they should NOT be considered completely, literally true from beginning to end.*

8. To lead the best, most meaningful life, one must belong to the one, fundamentally true religion.
9. “Satan” is just the name people give to their own bad impulses. There really is no such thing as a diabolical “Prince of Darkness” who tempts us.*
10. Whenever science and sacred scripture conflict, science is probably right.*
11. The fundamentals of God’s religion should never be tampered with, or compromised with others’ beliefs.
12. All of the religions in the world have flaws and wrong teachings. There is no perfectly true, right religion.*

**Reverse coded*