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Reducing Stigma Toward the Mentally Ill: The Impact of Exposure versus Information

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Abstract

This study explored the effects of exposure to the mentally ill, on reducing stigmatizing attitudes and increase empathy. Participants ($n = 22$ females, $n = 3$ males) were assigned to one of two conditions: (1) Exposure; (2) Information. In the Exposure condition subjects watched a video about a severely mentally ill man. The Information condition exposed participants to a video-taped lecture about mental illness. All participants completed the Community Attitudes Toward the Mentally Ill Scale (CAMI) and an empathy scale, before and after receiving their treatments. Results confirmed hypothesis one since participants in the Exposure condition showed an increase in positive attitudes ($F(1,23) = 9.78, p < 0.005$). Hypothesis two was not supported since participants showed no significant increase in empathy after either intervention ($F(1, 23) = 0.12, p = 0737$).

Reducing Stigma toward the Mentally Ill: The Impact of Exposure versus Information

Goffman (1963) defined stigma as an attribute of an individual that "makes him different from others…and of a less desirable kind-in the extreme, a person who is quite thoroughly bad, or dangerous, or weak" (p. 3). To add to Goffman's definition, stigma is a more specific, negative form of attitudes that is directed toward a specific group of people. Stigma has been further understood as a relationship between characteristics of a person and corresponding socially-constructed, negative stereotypes (Pinfold et al., 2003). Stigma can be defined along four social-cognitive dimensions including: (1) cues, like mental illness labels, (2) stereotypes, which include knowledge and beliefs about a social group (3) prejudiced attitudes, which involve making biased evaluations about a group of people and (4) discriminatory behaviors, which are negative actions toward members of the group (Teachman, Wilson, & Komarovskaya, 2006). This labeling and stereotyping leads to a type of "us" versus "them" mentality that fosters discrimination and stigmatization (Link & Phelan, 2006).

Negative social attitudes about mental illness present problems for those who are suffering from psychological disorders (Lipczynska, 2005). The stigma that goes along with mental illness acts as a serious barrier both for individuals seeking mental health treatment and those already diagnosed (Teachman, Wilson, & Komarovskaya, 2006). Appropriately accessing treatment may be hindered because people fear being labeled as "weird" or "crazy" and being the target of negative stigmatization (Lipczynska, 2005). Stigma has been shown to deter individuals from seeking care simply because they are motivated to avoid the label of "mentally ill" (Anglin, Link, & Phelan, 2006). The stigma of mental illness often makes routine life tasks such as getting a job, renting an apartment, interacting with peers and co-workers, and so on, difficult. These difficulties have been shown to occur regardless of the actual behavior of the labeled individual (Teachman, Wilson, & Komarovskaya, 2006). Link and Phelan (2006) point out that

another negative effect of stigma is increased stress which can have numerous consequences on mental and physical health. Thus, there is substantial evidence (Jamison, 2006; Link & Phelan, 2006; Lipczynska, 2005; Pinfold et al., 2003; Teachman, Wilson, & Komarovskaya, 2006) to suggest that the stigma against mental illness remains a serious issue that merits further study.

Mentally ill individuals are all too well aware of the stigma that accompanies their condition. Many experience a significant drop in self-esteem as a result of stigmatizing experiences. The stigma and discrimination that accompany the label of mental illness have perhaps just as big an impact as the underlying symptoms of mental illness (Lipczynska, 2005). There is evidence that many persons who suffer from mental illness internalize these stigmatizing views. Teachman, Wilson, & Komarovskaya (2006) found that both mentally ill individuals and a sample of the general public held equally negative views of mental illness. This finding suggests that the mentally ill, those who obviously suffer most from the stigma associated with mental illness, are also inadvertently perpetuating the stigma by internalizing negative stereotypes about mental illness. Jamison (2006) also suggests that people who have mental illness act to stigmatize themselves by making few demands and keeping their own expectations of both themselves and others very low.

Reducing Stigma toward the Mentally Ill

Recent research has focused on testing interventions to reduce the public's stigmatization of the mentally ill (Addison & Thorpe, 2003; Das et al., 2006; Pinfold et al., 2003). Some have looked at factual, knowledge-based interventions, while others have stressed the importance of contact with and exposure to the mentally ill. The following review of this literature reveals that gaps remain that need to be filled, however and provides the framework upon which the current study is based. Few studies have researched interventions that incorporate both factual

knowledge and exposure to the mentally ill.

A study by Angermeyer and Matschinger (1996) examined the influence of participants' previous contact with mentally ill individuals on their emotional responses to people suffering from mental illness, as well as the social distance that they desired to maintain from such individuals. The researchers hypothesized that increased personal contact with the mentally ill would improve reactions to them and the social distance desired would, in turn, decrease. Their results supported the hypothesis that promoting personal contact with the mentally ill is an effective strategy for counteracting stereotypes and producing fewer discriminatory reactions. As a result of positive forms of contact, the research suggests that people come to feel more secure with, and react more positively to individuals suffering from mental illness. Contact or exposure to the mentally ill seems to be a key determinant of attitudes toward the mentally ill.

Addison and Thorpe (2004) used the *Community Attitudes Toward the Mentally Ill (CAMI)* scale and a questionnaire designed to assess participants' attitudes and knowledge base concerning mental illness. The CAMI is a questionnaire developed by Taylor and Dear (1981) that consists of 40 statements which are rated in terms of participants' agreement with them on a standard 5-point Likert scale, rated from 1 (strongly disagree) to 5 (strongly agree). The scale is broken down into subscales highlighting four attitudinal factors including: (1) Authoritarianism which includes items such as, "The best way to handle the mentally ill is to keep them behind locked doors", (2) Benevolence with items such as, "We need to adopt a far more tolerant attitude toward the mentally ill in our society", (3) Social Restrictiveness which includes items like, "The mentally ill should not be given any responsibility", (4) Community Mental Health Ideology (CMHI) which contains items such as, "The best therapy for many mental patients is to be a part of a normal community." Each of the four subscales contained ten questions, five of the

phrases were phrased in the affirmative and five were phrased in the negative. Addison and Thorpe found reliability of the four sub-scales to range from high to satisfactory, CMHI (α = 0.88), social restrictiveness (α = 0.80), and benevolence (α = 0.76), and authoritarianism (α = 0.68).

The study by Addison and Thorpe (2004) was designed to test whether demographic factors such as, occupational/social class, education level, and amount of factual knowledge about mental illness contributed to the formation of certain attitudes toward the mentally ill. This study suggests that it may not be the demographic variables themselves that influence attitudes. Rather, the demographic variables may play a role in the amount and type of knowledge that different social groups have. The study found that although the relationship between the formation of attitudes and the accuracy of knowledge is not clear-cut, accurate knowledge does seem to play a part in the formation of attitudes toward the mentally ill. It was found that educational programs advocating factual knowledge about mental illness were not entirely effective in regulating and changing attitudes about mental illness on their own, rather, it was suggested that contact and experience with mentally ill individuals may play a more important role in reducing the stigmatization of the mentally ill.

A growing body of literature suggests that the right kind of positive contact or exposure to the mentally ill may be the key to reducing the stigmatization of the mentally ill (Addison & Thorpe, 2003; Angermyer & Matschinger, 1996; Watson & Corrigan, 2005). Contact with people with mental illness seems to be one of the most important factors that influence attitudes (Addison & Thorpe, 2003). Addison and Thorpe (2003) suggest that promoting personal contact with the mentally ill rather than stressing informative knowledge alone might have a greater effect in improving attitudes toward the mentally ill. Further support for the importance of

exposure over knowledge in interventions aimed at reducing the stigmatization of the mentally ill came from Watson & Corrigan (2005). They found that direct interaction and exposure to mentally ill persons helped to improve attitudes about mental illness more than did education-only interventions. This study provides promising findings about the impact contact can have on reducing the stigmatization of the mentally ill. Research with school-age children suggests that education combined with contact leads to greater attitude improvements than education alone (Watson & Corrigan, 2005).

Increasing Empathy toward the Mentally Ill

Empathy has been shown to be another factor in fostering positive attitude change toward the mentally ill (Elizur & Rosenheim, 1982). Empathy can be defined as a "vicarious emotional response to the perceived emotional experience of others" (Mehrabian & Epstein, 1972). As with positive attitudes, empathy can be increased through exposure to mentally ill individuals. Elizur & Rosenheim (1982) suggest that presenting factual educational information along with contact with or exposure to mentally ill individuals can help to increase empathy in participants. They found that the increases seen in empathy were still present after 6 months, which at least suggests the possibility of enduring change. This article stresses that even if an attitude change may not be seen as a result of an educational intervention, there may be a change in empathy which would also have a positive impact on the treatment of mentally ill persons in our society.

Elizur & Rosenheim (1982) used a self-reported subscale for empathy originally created by Mehrabian called the *Emotional Empathetic Tendency (EET) scale* in their study. The EET was designed to measure participants' empathetic emotional response in interpersonal situations. The questionnaire consists of 33 items which are answered on a nine-point Likert scale ranging from strong agreement (+4) to strong disagreement (-4). Higher scores indicate higher levels of

emotional empathy. An example question from the scale is "I cannot continue to feel OK if others around me are depressed." Their internal consistency test found that the EET had a reliability of 0.73.

Educational Interventions

Das, et al. (2006) developed an educational intervention that discussed causal factors, treatment possibilities, symptoms, prevalence, and diagnostic information. The researchers found that there were some changes in participants' explanatory models about the causes and consequences of mental illness after their educational intervention but many of the explanatory models persisted. This study suggested that further research was warranted to determine the ideal components of an effective educational intervention in order to change explanatory models of mental illness. Specifically, the researchers suggested that future research should attempt to combine factual information with exposure to the mentally ill in an educational intervention.

Pinfold et al. (2003) suggest that there is limited evidence about what types of programs successfully challenge negative attitudes and stereotypes about mental illness. They reported that short educational interventions can produce changes in participants' reported attitudes toward people with mental illness. This study suggested that a culturally-sensitive, multi-level approach be taken when developing an educational intervention to fight against the stigmatization of the mentally ill. Specifically, they identified three important factors to include: education about mental illness, positive exposure to mentally ill individuals, and the empowerment of such individuals. Although this article points out that there are problems with current intervention attempts, it does support the claim that short educational interventions can in fact produce positive changes in attitudes toward people with mental illness.

Despite the recent efforts to reduce stigma, a pervasive negative view of mental illness

still remains on both implicit and explicit levels across both diagnosed and healthy samples (Teachman, Wilson, & Komarovskaya, 2006). The evidence describing what actually works in practice is still limited and underdeveloped (Pinfold et al., 2003). A negative halo effect is still associated with mental illness. Psychologists need to make an effort to educate the public about stigma and its profound effects to reduce the pain and discrimination that accompany stigma.

The Current Study

The current study focuses on the development of an educational intervention that aims to reduce participant*s'* stigmatizing attitudes about mental illness by providing factual information about mental illness and exposure to an actual mentally ill individual. The research question for this study was: Would an intervention that incorporates both factual information about mental illness and exposure to a mentally ill person be more effective in reducing participants' stigmatizing attitudes and increasing their levels of empathy toward the mentally ill than an information only intervention? A study was designed in which a videotaped lecture was presented to one group of participants which provided basic factual information about several forms of mental illness, including Schizophrenia, Bipolar disorder, and Schizoaffective disorder. Another group of participants watched a documentary that provided a more in-depth, realistic, and humanizing portrayal of a mentally ill individual named Robert. The first group tested whether or not factual information had an effect on attitude formation and the second group demonstrated whether or not an intervention that stresses both factual information and exposure to the mentally ill plays a role in reducing the amount of stigmatizing attitudes toward mental illness. The first group served as the Information-Only (control) condition and the second group served as the Exposure (treatment) condition.

It was hypothesized that: (1) Participants in the Exposure condition ("Robert Documentary") would show a greater decrease in stigmatizing attitudes toward the mentally ill as compared to the Information-Only condition ("Professional Lecture"). (2) Participants in the Exposure condition would show an increase in levels of empathy toward the mentally ill, whereas the Information-Only participants would show no increase, or less of an increase.

Method

Participants

Students ($N = 25$) from a small liberal arts college in a rural part of southeastern Indiana participated in this study. While participants were from a variety of majors, most students were enrolled in psychology classes and some received extra credit for participating in the study, six (24%) were psychology majors. Three of the participants were male (12%) and twenty-two of the participants were female (88%) ranging in age from 18-22 (M= 20 years, SD= 1.1). It is important to note that participants had a wide range of previous contact or experience with mental illness prior to participating in the study. It is also important to note that participants were asked to circle all categories that applied (none, acquaintance, friend, family member, self) and that a number of participants reported having previous contact or experience with mental illness in more than one category.These participant characteristics will be discussed further in the result section below.

Materials

A description of the study and consent from (see Appendix A) and a general demographic questionnaire were designed to obtain basic information about participants such as their age, year in school, gender, and major (see Appendix B). Previous experience with mental illness was also

assessed on the demographic questionnaire. Five categories were used to assess how close previous contact with mentally ill individuals was. The categories for contact with mental illness included: none, acquaintance, family member, friend, and self. An open ended question appeared at the end of the demographics questionnaire that asked that participants to discuss how their prior experience with mental illness and/or previous contact with the mentally ill has affected them.

Scales

An empathy scale based on the *Emotional Empathetic Tendency Scale (EET)* was used to assess participants' levels of emotional empathy toward the mentally ill. The original scale was modified to include questions specifically about the mentally ill. The final scale consisted of 16 items representing eight concepts with a positive and a negative counterpart for each concept. For example, one of the concepts was sympathy for the mentally ill. The affirmatively phrased statement was "The mentally ill deserve our sympathy" while the negatively phrased statement was "People make too much of the feelings and sensitivity of the mentally ill". In creating the scale this way, it was hoped that if participants were rating high agreement with the positive statements, they would be rating high disagreement with the negative statements and vice versa. Participants were asked to rate their agreement with the 16 statements on a five-point Likert scale from 1 (strongly disagree) to 5 (strongly agree) (see Appendix C). In addition to the empathy scale, *The Community Attitudes Toward Mentally Ill Scale (CAMI)* (Taylor & Dear, 1981) was used to assess participants' attitudes toward the mentally ill. Participants were asked to rate their agreement with the 40 statements on a standard 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree) (See Appendix D).

Videos

A sixty-minute documentary film, written by Jay Neugeboren (2002) entitled *Imagining Robert: My Brother, Madness, and Survival* was used to expose participants to a very real and humanizing portrayal of a mentally ill individual (Hott & Garey, 2002). The documentary was made by two brothers, Robert who has suffered from long-term mental illness, and Jay who has been Robert's primary caretaker over the last 38 years. Robert experienced his first psychotic episode during his first year of college and since then has been hospitalized and re-hospitalized over fifty times and has received a variety of diagnoses, including Schizophrenia and Manic-Depressive (Bipolar) disorder. The film was selected because it provides detailed factual and personal information about Robert and his mental illness and it discusses how the family coped with Robert's illness. The film offers a very realistic and humanizing portrayal of Robert and it includes home videos of him, current interviews with him, and a substantial amount of footage of him interacting with others. The film shows Robert to be warm, caring, intelligent, and funny, despite his mental illness.

A 45-minute video was created by the researcher to be used in this study that covered some general information about several forms of mental illness. A licensed Clinical Psychologist and director of a college counseling center was videotaped giving a lecture on Schizophrenia, Bipolar disorder, and Schizoaffective disorder. Some information included about the mental disorders was: causal factors, treatment possibilities, symptoms, prevalence, and diagnostic information. The videotaped lecture contained only factual information. The lecturer was specifically instructed not to humanize the information with any case examples, since this condition acts as the Information-Only control (see Appendix F).

Procedure

The basic research design of this study follows a pre- / post-intervention design. All

participants began by reading a brief description of the study. Once informed consent was

obtained, they filled out a general demographic questionnaire. All participants then filled out the

CAMI and the Empathy scales before they received either the experimental or control treatment.

The participants were separated into their respective groups according to the session for which

they signed up. Conditions were assigned on alternate days each week. One group served as the

Information-Only control group and the other as the experimental, Exposure group. The

Information-Only group watched the 45-minute videotaped lecture. The Exposure group watched

Imagining Robert (Hott & Garey, 2002). The CAMI and the Empathy scale were again

administered to the participants after viewing their respective films. For the rest of the paper,

these two conditions will be referred to by the titles of the videos that participants saw in each

condition: "Professional Lecture" for the Information-Only condition and "Robert Documentary"

for the Exposure condition.

<div align="center">Results</div>

To determine the effects of the two interventions, Information-Only and Exposure, had

on decreasing stigmatizing attitudes and increasing empathy an Empathy scale and the CAMI

were administered both before and after the interventions. Empathy was analyzed using a 2

(condition) by 2 (time) mixed factorial design with repeated-measures on the second factor. The

interaction between time and treatment was not found to be significant, $F(1,23) = 0.12$, $p = $

0.737.

Attitudes, as measured by the CAMI, were also analyzed using a 2 (condition) by 2

(time) mixed factorial design with repeated-measures on the second factor. The expected

interaction between time and treatment was significant, $F(1,23) = 9.78$, $p < 0.005$. In the

Information-Only group, scores decreased from 149.8 to 150.9, while in the Exposure group

scores increased from 150.9 to 155.3. Tests of simple main effects indicated that the Exposure group had significantly more positive attitudes than the Information-Only group at post-test ($p <$ 0.05) but not at pre-test ($p = 0.097$) (see Figure 1).

The four subscales of the CAMI were similarly analyzed using a 2 (condition) by 2 (time) mixed factorial design with repeated-measures on the second factor. The expected interaction between time and treatment was significant for the Benevolence subscale, $F(1,23) = 6.20$, $p <$ 0.05. In the Information-Only group, scores on the Benevolence subscale decreased from 39.4 to 38.9, while in the Exposure group scores increased from 38.8 to 40.3. Tests of simple main effects indicated that the Exposure group had significantly more benevolent attitudes than the Information-Only group at post-test ($p < 0.05$) but not at pre-test ($p = 0.406$) (see Figure 2). The interaction between time and treatment was not found to be significant for the Authoritarianism subscale, $F(1,23) = 2.83$, $p = .106$ or the Social Restrictiveness subscale, $F(1,23) = 2.82$, $p = 0.106$. The Community Mental Health Ideology subscale was found to approach significance, $F(1,23) = 3.72$, $p = 0.066$.

Statistical comparisons confirmed hypothesis one since the Robert Documentary group had more positive and benevolent attitudes, and thus less stigmatizing attitudes, after the intervention than the Professional Lecture group. Hypothesis two was not supported in this study because statistical comparisons were not significant for changes in empathy. It is important to note that a surprising, 76% of participants, reported having some previous experience or contact with mentally ill persons. While six participants reported having no prior contact or experience with mental illness, four reported knowing an acquaintance with mental illness, four reported having a friend that dealt with mental illness, six reported having a family member with mental illness, and five even reported suffering from some form of mental illness themselves.

Discussion

Results confirmed hypothesis one since stigmatizing attitudes decreased overall and benevolent attitudes increased as a result of the Exposure intervention. Participants in the Robert Documentary condition showed significant positive changes in attitudes after the intervention while participants in the "Professional Lecture" condition showed no such changes. This study has important implications about reducing the stigma of mental illness. This intervention proved to be effective in reducing stigmatizing attitudes and increasing benevolent attitudes toward the mentally ill. Since the Exposure intervention proved to be effective in reducing participants' stigmatizing attitudes and increasing their benevolent attitudes toward the mentally ill, it could serve as a model on which other studies could base their interventions to decrease mental illness stigma. This study supports the claim that exposure to a mentally ill person can be more effective at reducing stigmatizing attitudes than the mere presentation of factual information about mental illness.

Hypothesis two was not confirmed in this study because there were no significant changes in empathy levels in either condition. It is possible that the Robert Documentary does not increase participants' levels of empathy. However, an alternative interpretation is also possible. Perhaps the reason for this lack of a significant change in empathy scores could be attributed to the fact that participants in this sample displayed relatively high levels of empathy prior to participating in the study. Scores on the pre-intervention Empathy scale ranged from 49 to 70 out of a possible 80 (M = 61.4). All participants in the sample scored in the top third of the Empathy scale and nearly half of them scored above 65 out of 80. These initially high starting empathy levels and relatively low levels of stigmatizing attitudes may have restricted how much change could be evoked by the intervention. If empathy levels of participants had started at a

lower or more neutral level it is possible that significant changes in empathy could have been elicited by the Robert Documentary.

The demographics questionnaire allowed us to explore why the sample in this study was so empathic to begin with. This sample indicated a high level of previous contact with mental illness prior to the study. Previous research has shown that people who have previously come into contact with mentally ill individuals believe them to be less dangerous and thus fear them less than individuals who have not had prior contact with the mentally ill (Angermeyer & Matschinger, 1996). People with prior contact also have been shown to be more willing to enter into social relationships with mentally ill individuals and they generally adopt a more benevolent and accepting attitude towards the mentally ill (Taylor & Dear, 1981). It was expected that as a result of the exposure to a mentally ill individual, the participants in the Robert Documentary condition would come to feel less fearful or insecure about the mentally ill and would therefore report fewer negative attitudes after participating in the study. However, since the participants came into the study with high levels of previous exposure, the effects of the additional exposure would likely be minimal.

Although this study provided some insight into what interventions are successful in reducing stigmatizing attitudes, there are still a number of unanswered questions that could be explored in future research. Future research should aim to test interventions on a less empathic sample who hold more stigmatizing attitudes to begin with to see if the intervention could have a significant impact on increasing empathy and decreasing stigmatizing attitudes. Future research is needed to test this intervention with more participants and a more diverse sample since this sample was predominately female and Caucasian. It would also be beneficial if future research explored gender differences in stigmatizing attitudes and empathy levels for the mentally ill by

including equal numbers of men and women in the sample. It is interesting to note that there was a trend with the benevolence subscale of the CAMI. As stigmatizing attitudes decreased, benevolent attitudes increased. Thus, more research is also needed to explore the role benevolence plays in reducing stigmatizing attitudes and how this might relate to empathy.

With or without future studies, the significance of this topic is important for psychologists and society to recognize because the social stigma of mental illness hurts individuals and society. Thus it is important to understand the negative effects that stigma can have and study possible ways to reduce this problem in our society. If an intervention could be created that significantly reduced the stigmatization of the mentally ill and increased the level of empathy people had for mentally ill individuals in our society, it would have a great impact on making the world a better place. Such an intervention could be placed in schools to expose children to a positive representation of the mentally ill early, before they have a chance to create a negative stereotype which manifests into stigmatizing attitudes toward the mentally ill. If such an intervention were to be implemented, the mentally ill would no longer have to fear the label associated with their illness and they may be more willing to access the treatment and support that they need to get well. The social stigma of mental illness will not go away until we actively work to fight against it by creating and testing interventions to reduce the ongoing stigma associated with mental illness.

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Appendix A: Study Description/ Informed Consent

This research is being conducted by Stephanie Turner, a senior psychology major at Hanover College. The experiment in which you are asked to participate is designed to examine students' perceptions and understandings about psychological differences between people. You will fill out a brief demographic questionnaire and two short surveys. You will also watch a video about mental illness. After you have finished filling out the surveys and watching the video, you will be debriefed.

The entire experiment may take either 60 or 90 minutes. There are no known risks involved in being in the study, beyond those of everyday life. The information you provide during the experiment is completely anonymous and at no time will you be associated with the responses that you give. If you have any questions about what you will be doing in the study or about the study itself, feel free to ask them now or at any time during your participation.

If you have any questions after the study, please contact Stephanie Turner at turners@hanover.edu or Michelle Mamberg at mamberg@hanover.edu or in room 255 of the Science Center.

If you feel any discomfort during or after participating in this study please feel free to contact Katie DineYoung x6842, Gary Petiprin x7399, Michelle Mamberg x7239, or Michelle Bartel x6745.

_____

I acknowledge that I am participating in this study by my own free will. I understand that I may refuse to participate or stop participating at any time during the study. If requested, a copy of this consent form may be provided to me.

_____   _____
Signature   Date

Appendix B: Demographic Questionnaire

Please complete the following as accurately as possible.

1. **Sex:**   Male   Female

2. **Age:** _____

3. **Year in School:**   Freshman   Sophomore   Junior   Senior

4. **Major:** _____

5. **Previous Experience/Contact with Mental Illness:** (circle all that apply)

None   acquaintance   friend   family member   self

6. **Is there anything else about your prior experience with mental illness and/or previous contact with mentally ill individuals that affected you?**

_____

_____

_____

_____

_____

Appendix C: Empathy Toward the Mentally Ill Scale

Survey 1:

Read each statement carefully then decide to what extent you agree or disagree with the statement. Then, write the number that corresponds with the extent to which you agree or disagree with the statement in the blank preceding each statement.

There are 5 different levels of agreement/disagreement from which to choose, they are:

1= Strongly   2=Disagree   3=Neutral   4= Agree   5=Strongly
Disagree   Agree

_____ 1. I get very angry when I see someone being ill-treated.

_____ 2. I rarely let the feelings of others affect me.

_____ 3. The mentally ill sometimes act out for no apparent reason.

_____ 4. I cannot continue to feel OK if people around me are depressed.

_____ 5. It makes me sad to hear stories about the severely mentally ill.

_____ 6. The mentally ill deserve our sympathy.

_____ 7. The severely mentally ill are probably unfriendly.

_____ 8. I am very upset when I see people feeling psychological discomfort.

_____ 9. I would rather work in a computer lab than be a therapist.

_____ 10. There is no reason for the severely mentally ill to be feared.

_____ 11. People make too much of the feelings and sensitivity of the mentally ill.

_____ 12. Seeing people in distress doesn't bother me.

_____ 13. I would rather be a social worker than work in a job training center.

_____ 14. The misfortunes of others don't bother me.

_____ 15. In many ways, the mentally ill are just like the rest of us.

_____ 16. I am annoyed by mentally unstable people who are just sorry for themselves.

Appendix D: Community Attitudes Toward the Mentally Ill Scale (CAMI):

Survey 2:

Read each statement carefully then decide to what extent you agree or disagree with the statement. Then, write the number that corresponds with the extent to which you agree or disagree with the statement in the blank preceding each statement.

There are 5 different levels of agreement/disagreement from which to choose, they are:

1= Strongly   2=Disagree   3=Neutral   4= Agree   5=Strongly
Disagree   Agree

_____ 1. One of the main causes of mental illness is a lack of self-discipline and will power.

_____ 2. The mentally ill have for too long been the subject of ridicule.

_____ 3. The mentally ill should not be given any responsibility.

_____ 4. Residents should accept the location of mental health facilities in their

neighborhood to serve the needs of the local community.

_____ 5. The best way to handle the mentally ill is to keep them behind locked doors.

_____ 6. More tax money should be spent on the care and treatment of the mentally ill.

_____ 7. The mentally ill should be isolated from the rest of the community.

_____ 8. The best therapy for many mental patients is to be part of a normal community.

_____ 9. There is something about the mentally ill that makes it easy to tell them from

normal people.

_____ 10. We need to adopt a more tolerant attitude toward the mentally ill in our society.

_____ 11. A woman would be foolish to marry a man who has suffered from mental illness, even

 though he seems fully recovered.

_____ 12. As far as possible, mental health services should be provided through community

based facilities.

_____ 13. As soon as a person shows signs of mental disturbance, he should be hospitalized.

1= Strongly Disagree **2=Disagree** **3=Neutral** **4= Agree** **5=Strongly Agree**

_____ 14. Our mental hospitals seem more like prisons than like places where the mentally

ill can be cared for.

_____ 15. I would not want to live next door to someone who has been mentally ill.

_____ 16. Locating mental health services in residential neighborhoods does not endanger

local residents.

_____ 17. Mental patients need the same kind of control and discipline as a young child.

_____ 18. We have a responsibility to provide the best possible care for the mentally ill.

_____ 19. Anyone with a history of mental problems should be excluded from taking public

office.

_____ 20. Residents have nothing to fear from people coming into their neighborhood to

obtain mental health services.

_____ 21. Mental illness is an illness like any other.

_____ 22. The mentally ill don't deserve our sympathy.

_____ 23. The mentally ill should not be denied their individual rights.

_____ 24. Mental health facilities should be kept out of residential neighborhoods.

_____ 25. The mentally ill should not be treated as outcasts of society.

_____ 26. The mentally ill are a burden on society.

_____ 27. Mental patients should be encouraged to assume the responsibilities of normal life.

_____ 28. Local residents have good reason to resist the location of mental health services in

their neighborhood.

1= Strongly   2=Disagree   3=Neutral   4= Agree   5=Strongly
    Disagree   **Agree**

_____ 29. Less emphasis should be placed on protecting the public from the mentally ill.

_____ 30. Increased spending on mental health services is a waste of tax dollars.

_____ 31. No one has the right to exclude the mentally ill from their neighborhood.

_____ 32. Having mental patients living in residential neighborhoods might be good

therapy, but the risks to residents are too great.

_____ 33. Mental hospitals are an outdated means of treating the mentally ill.

_____ 34. There are sufficient existing services for the mentally ill.

_____ 35. The mentally ill are far less of a danger than most people suppose.

_____ 36. It is frightening to think of people with mental health problems living in residential

neighborhoods.

_____ 37. Virtually anyone can become mentally ill.

_____ 38. It is best to avoid anyone who has mental problems.

_____ 39. Most adults who were once patients in a mental hospital can be trusted as

babysitters.

_____ 40. Locating mental health facilities in a residential area downgrades the

neighborhood.

Appendix E: Debriefing Form

   The study in which you just participated was designed to measure the effects of two conditions aimed at reducing stigmatizing attitudes and increasing empathy toward the mentally ill. You either watched a video of a professional talking about mental illness in general, which was the control condition (i.e., only information was provided) or a video that provided an empathic portrayal of an actual mentally ill individual (i.e., the treatment condition). I will be testing whether the treatment condition has a greater effect in reducing stigmatizing attitudes and increasing empathy toward the mentally ill than the control condition.

   Please do not discuss this study with other potential participants until the semester has ended. If people know what I am looking for before the study begins, they may respond differently, jeopardizing the results of the study.

   As soon as the results from this study are available you can contact me if you would like to read about them.

   Again, if you felt any discomfort during or after participating in this study please feel free to contact Katie DineYoung x6842, Gary Petiprin x7399, Michelle Mamberg x7239, or Michelle Bartel x6745.

   If you have any questions or comments about this research, please contact Stephanie Turner at turners@hanover.edu or Michelle Mamberg x7239. Thank you for participating, your time and participation are much appreciated!

Appendix F: Information-Only, Video Lecture Outline:

Instructions to licensed psychologist:

Please review the following outline on which you should base your discussion of mental illness. Frame your discussion as you would a lecture to a group of introductory psychology students since they will likely make up the majority of the participants. Do not assume that the audience will have any previous knowledge about mental illness. **Keep in mind that this video is serving as an Information-Only control condition so no humanizing or empathic material should be present**. The outline begins with an overview of several different forms of mental illness including: schizophrenia, bipolar disorder, and schizoaffective disorder. Any or all of the following can be discussed: causal factors, treatment possibilities, symptoms, prevalence, and diagnostic information. The whole lecture should be about 45 minutes long.

I.   Schizophrenia
    A. Two Categories of Symptoms
        i. Positive- reflect an excess or distortion of normal functions
        ii. Negative- reflect a diminution or loss of normal functions
    B. Types of Symptoms
        i. Delusions- erroneous beliefs that usually involve a misinterpretation of perceptions or experiences
        ii. Hallucinations- can occur through any of the senses; auditory most common
        iii. Disorganized speech and thinking
        iv. Disorganized behavior (i.e. catatonic)
        v. Flat affect
        vi. Avolition
    C. Diagnostic Criteria
    D.   Prevalence
    E. Etiology
    F. Treatment options
    G. Various subtypes

II.   Bipolar Disorder
    A. Depression
    B. Mania
    C. Diagnostic Criteria
    D. Prevalence
    E. Etiology
    F. Treatment Options

III.   Schizoaffective Disorder
    A. Features of the Disorder
    B. Diagnostic Criteria
    C. Prevalence
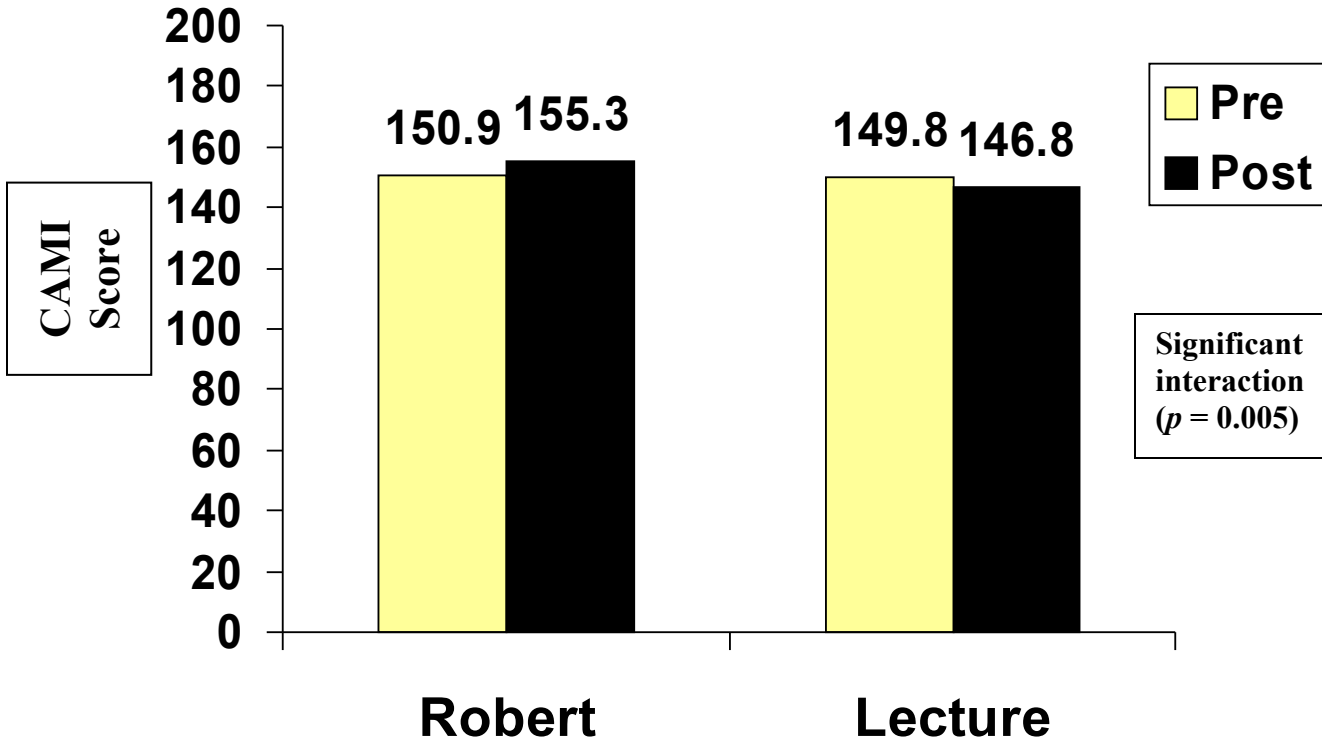   D. Etiology

E. Treatment Options

Figure 1. Pre- /Post- CAMI Changes

Figure 2. Pre- /Post- Benevolence Changes