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The Development Of Mental Illness Stigma: The Role Of Perceived Social Support, Social Proximity, And Help-Seeking Behavior

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THE DEVELOPMENT OF MENTAL ILLNESS STIGMA: THE ROLE OF PERCEIVED SOCIAL SUPPORT, SOCIAL PROXIMITY, AND HELP-SEEKING BEHAVIOR

BY

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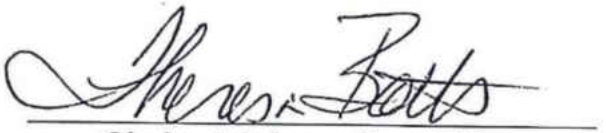

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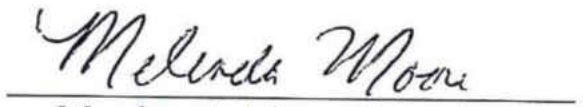

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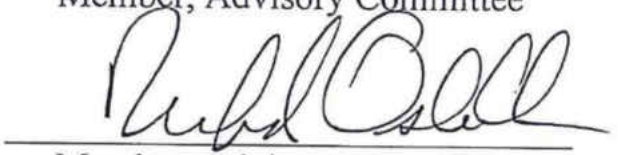

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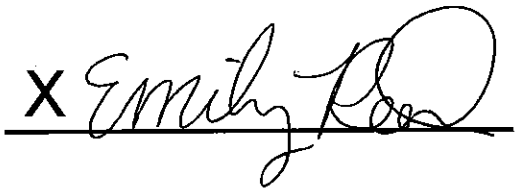
X 

MENTAL ILLNESS STIGMA: THE ROLE OF PERCEIVED SOCIAL SUPPORT, SOCIAL PROXIMITY, AND HELP-SEEKING BEHAVIOR

BY

EMILY REED

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DEDICATION

This thesis is dedicated to my father Bradley Reed for loving me, supporting me, and allowing me to forge my own path while always pushing me to be the best version of myself.

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ABSTRACT

The current study sought to explore the relationships mental illness stigmatization may have with perceived social support, proximity, and help-seeking behavior. Based on findings from previously conducted studies, hypotheses were formulated in order to further analyze how perceived social support, proximity, and help-seeking behavior may impact an individual's tendency to stigmatize mental illness. 203 Eastern Kentucky Students participated in this study to test these hypotheses. These participants took part in an online study that measured their perceived social support based on their family environment, their proximity to those with a mental illness or mental illness in general, their attitudes regarding seeking out professional help regarding mental health, and their level of stigma. The hypotheses of the current study were not supported by the analyses conducted, and one hypothesis was proven to be contradictory indicating that proximity tends to correlate with higher rates of stigma as opposed to lower rates. The other findings were not significant.

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CHAPTER I

INTRODUCTION

Although the treatment of mental illness has come a substantially long way over the past several decades, there still seems to be some societal resistance to fully accepting it as a real and life-threatening implication. Mental illness has only increased in prevalence during the past few decades, due to the topic slowly becoming more accepted and paid attention to, especially by researchers. According to the National Alliance on Mental Illnesses 18.5% – which is equivalent to about 43.8 million Americans – experience mental illness in a year (Mental Health by the Numbers). Of these numbers, one in twenty-five (about 10 million) live with a serious disorder including schizophrenia, bipolar disorder, or major depression. These numbers are large and are only growing, with the risk factors increasing as well. What is even more significant is that about 60% of adults and 50% of children with a mental illness received no treatment at all in the previous year, while only 38.5% of those who did receive treatment received treatment that was considered "minimally adequate" (Mental Health by the Numbers). Despite the fact treatment methods have come relatively far since the days of increased institutionalizing and incarceration of the mentally ill, treatment itself still has a long way to go if barely half of those affected and seeking out help receive what is deemed to be sufficient (Mental Health by the Numbers).

One possible explanation as to why individuals are not seeking out treatment for their symptoms is that illnesses based in the mind and the brain are not as widely understood by the general public as they should be. This idea was coined as mental health literacy by Jorm, Korten, & Jacomb (1997) and can be seen in the way mental illness is depicted across different platforms. There seems to be a persistent negative stigma

surrounding those who suffer with such illnesses. These negative stereotypes are consistently portrayed throughout pop culture and the media in general, which can have a substantial impact on stigma. Mental illness is consistently presented to viewers via the mass media in many different ways, and this representation is usually inaccurate and primarily focused on the negative, extreme characteristics of it (Wahl, 1992). It was also determined that what the public sees from the media helps to mold their perception of certain mental illnesses (Wahl, 1992). For example, in movies and television shows, there are instances of characters with mental illnesses that are seen as crazy, dangerous, unintelligent, and inferior. Even the dialogue surrounding mental illness is typically negative and places those with such diseases in an inferior light. There are also brands that essentially cash in on those stereotypes – for example, there is a pre-workout performance enhancing powder that is entitled "Schizo." Most movies surrounding topics such as schizophrenia and dissociative identity disorder are dramatized for entertainment purposes. The character afflicted is typically dangerous and to be feared and avoided in order to ensure personal safety. It is the constant influx of negative stigmatization such as these that further instigate these dangerous and negative stereotypes.

There is a blatant danger that surrounds the existence of such stigmas. Concerning mental health, fear of being labeled as flawed and fear of being discriminated against may impact people's decision to seek out treatment for their affliction. Also, those who do require treatment but hold the negative stereotypes themselves, may be resistant and in denial concerning the help they need. Mental illness is utilized as a constant joke throughout today's media and cultural tendencies. Disorders such as obsessive-compulsive disorder, depression, bipolar disorder, and schizophrenia are regularly used

as adjectives to humorously describe oneself as, for example, being “depressed”, which is seen as more of a mundane, passing phase instead of the anomaly it actually is. Although some of these circumstances are not outright insults against the mentally ill, downplaying the severity can be equally as harmful.

The present study seeks to answer the questions surrounding the perpetuation of stigmatization of mental illness, as well as what can be done to work on eliminating it in the future. This study will focus on multiple variables that may impact and predict the development of negative stigmas and opinions surrounding mental illness. These variables are 1) perceived social support, 2) proximity to a mental illness (i.e., a family member, a friend, or a colleague), and 3) help-seeking behavior. Through the use of an extensive literature review of past studies, and data collection via surveys, the relationships between these variables and stigmatization will be analyzed and discussed.

CHAPTER II

LITERATURE REVIEW

Defining Stigma

A stigma, according to Link & Phelan (2001), is defined as existing "when elements of labeling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them." Stigmas concerning mental illness can exist from outside influences such as from peers and colleagues, or can be self-driven. The interplay of these stigmas has proven to reduce treatment-seeking behaviors (Quinn, Williams, & Weisz, 2015) which can be detrimental to an individual's mental health and overall well-being. There have been numerous studies conducted that illustrate the potential dangers of these negative stigmas. Due to these societal views and beliefs of mental illness, many people who suffer from various psychological disorders either do not seek treatment at all, or do not completely comply with their doctor's treatment plan (Corrigan, 2004). Many aspects of the psyche are at risk when concerning these stigmas: self-concept and esteem are at risk of depletion, relationships can deteriorate due to both self and social-stigmas, and individuals with mental illness are at risk of discrimination from their peers, potential employers, etc. (Corrigan, 2004). Also, it seems as if mental illness and its stigmas move in a cyclical way – stigmas tend to prevent individuals from seeking or following through with treatment, and those actions tend to worsen the illness itself (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003).

One factor that is impacted by stigma is social distancing. Social distance is how comfortable an individual is in regards to being around someone they perceive to be different, or in this case, mentally ill (Marie & Miles, 2008). Marie and Miles (2008)

found that social distancing behaviors and the development of stigmas typically arise due to diagnostic labels, as opposed to the symptoms themselves. This fact indicates that it is a societal and cultural attitude that provides those less familiar with mental health with what they should expect. These expectations can lead to fear and increased social distance (Marie & Miles, 2008). Barczyk (2015) conducted a study in which they found that those who held more stigmas regarding mental illness also held the belief that there was little potential for the individual afflicted to recover. This in-turn led to greater instances of social distancing behaviors. Previous research has also noted that these tendencies to want to be more distant from a person with a mental illness significantly decrease when the person is more familiar with mental illness (Angermeyer & Matschinger, 1996).

Societal views of individuals with mental illness are usually anything but positive. Typically, it has been reported that those with a mental illness are labeled as dangerous (Corrigan et al., 2003), unpredictable, or hard to talk or relate to (Connery & Davidson, 2006). The study conducted by Connery & Davidson (2006) in Scotland found that the participants from the United States believed that informing people of their depressive status would result in difficulty with finding a job. They also held a fear and belief surrounding both obtaining quality health insurance and it being enough, and maintaining stable friendships (Connery & Davidson, 2006). This fear did not come from doubting their own abilities, but from the "stigmatising attitudes" they claimed to believe many hold. Corrigan & Watson (2002) explained the phenomenon of stigma by breaking it down into two distinct parts: social or public stigma, and self-stigma. Social stigma is highly influenced by culture, and the culture in the United States provides a large amount

of images and messages that are related to mental illness and its negative associated stigma. This influences those with such illnesses to agree and act congruently to those stereotypes, which eventually leads to the development of a self-stigma (Corrigan & Watson, 2002).

A self-stigma is a belief that an individual holds about their own capabilities and definitive, stable features. More specifically, a self-stigma is a belief that one holds about their own mental illness and its ramifications (Zhang, Mak, & Chan, 2017). These beliefs are internalized thoughts due to rejection and discrimination they may have experienced during the duration of their illness (Zhang et al., 2017). As a way to cope and prepare for everyday life, many people tend to anticipate and eventually assume a certain interaction will occur in response to their presence. This, according to Link, Wells, Phelan, & Yang (2015) is called the symbolic interaction stigma. In this symbolic interaction stigma, the individual with the mental illness will attempt to modify or force certain behaviors or reactions in the expectation that their peers will react in a specific way. They could act in a variety of ways, such as concealing their symptoms, avoiding treatment-seeking behaviors, or even social isolation (Link et al., 2015). This study illustrates how impactful both self and public stigma can be, and how they can interact with and feed on each other.

There are certain psychological needs that an individual must consistently meet in order to live a happy and fulfilled life. Zhang et al. (2017) claim that there are four essential primal needs: 1) security which gives way to self-preservation, 2) belonging and social status, 3) personal growth and a sense of an individual identity, and 4) personal worldview. There can be many things that serve as a threat to these needs, which can be

detrimental to mental health. These threats can be even more detrimental to the treatment and recovery process of a mental illness. One of the key aspects of recovery from any sort of mental illness is reestablishing a sense of identity, as well as a sense of personal growth and resilience. Those four primal needs revolve around a confident and strong sense of self and capability. Holding on to any sort of self-stigma can deteriorate the healing process, as well as the process of fulfilling those necessary needs.

Empowerment is another key factor in an individual's recovery from mental illness. When those affected by mental health issues rise above their symptoms and strive to gain control over what may be negatively impacting their wellbeing, they build up a sense of empowerment which often leads to lasting resilience (Zhang et al., 2017). Factors that feed into self-stigmatization contradict that empowerment and can lead into a relapse of symptoms or a falling back into maladaptive thinking (Zhang et al., 2017). Some symptoms of mental illness can be so debilitating, that many will isolate themselves. This in-turn leads to a lack of social fulfillment, which can lead to the person applying even more negative stereotypes to themselves concerning their worth and capabilities. These negative stereotypes can greatly decrease both self-efficacy and self-esteem, greatly increasing the chances of heightened symptomology coinciding with a disorder (Zhang et al., 2017).

Stigmatization and Discrimination

Although the attitudes toward mental illness have somewhat improved over the past few decades, studies show that there is still much avoidance and social distancing behaviors associated with it (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003). While those with certain physical ailments are void of responsibility over their condition,

those with any sort of mental illness are seen as individually responsible for their sufferings by the general public. This belief held by those without the illness can cause them to feel anger and disapproval towards those with mental health problems, and can also make them feel more unwilling to help or be empathetic (Elliott & Doane, 2015). This lack of acceptance, as well as the lack of a full understanding of what mental illness is, limits those individuals who do experience such afflictions, as it can hold them back from fair employment opportunities as well as having an opportunity for quality housing (U.S. Department of Health and Human Services,1999). According to Goffman (1963), those that "normal" people perceived to be inferior to themselves due to one attribute or many, have lesser life chances due to this belief. These chances are decreased because of some differential personality characteristic that sets them apart from the social norm. Regarding mental illness, many are perceived as dangerous or in some way incompetent. This view held by potential employers and peers greatly prevents them from achieving their actual full potential (Goffman, 1963).

There are three components to mental illness stigma held by the public as opposed to the self: stereotype, prejudice, and discrimination (Corrigan et al., 2003). A stereotype is a label applied to an individual or group of individuals, a prejudice is an idea one might hold towards that group or an attitude they might have, and discrimination is behavior based on that prejudice and stereotype. Having these negative ideas about mental illness may result in an array of potentially harmful situations for the person with the illness. These include, but are not limited to, segregation, hostility, avoidance, and withholding help (Corrigan et al., 2003). Coercion is a big threat to those seeking out treatment for a mental illness. Those with a mental illness that leads to them being perceived as

dangerous may be coerced into getting a form of treatment that could be detrimental to their overall wellbeing. Typically, this is a type of treatment that is forced upon the patient and that will yield the quickest results. For the individual, these results are usually unsatisfactory, as well as aversive, and prevent them from wanting to seek treatment in the future (Corrigan et al., 2003). Although forced hospitalization has decreased in recent years, the public belief about those with mental illness has remained the same. Specifically, many believe that those with more serious disorders should be institutionalized as opposed to receiving any sort of outpatient treatment (Corrigan et al., 2003).

Treatment Implications

Numerous studies have been conducted that show the efficacy of therapy on a variety of psychological disorders. While some individuals seek pharmacotherapy for help from a psychiatrist and some seek out psychotherapy in the form of cognitive behavioral therapy, interpersonal therapy, etc., it has been proven that either treatment is better than no treatment at all (DeRubeis, R., Siegle, G., & Hollon, S., (2008). Therapy serves to increase a client's resilience. It also teaches valuable coping skills to aid them in effectively handling future symptomology or trauma. A client's willingness to engage in treatment is what makes it the most successful, and the factors that may impact that willingness need to be fully understood so that they may be avoided (Owen, Thomas, & Rodolfa, 2013).

One group throughout society that is impacted greatly by mental illness is those in the military. 17-33% of soldiers who partook in the Operation Iraqi Freedom or the Operation Enduring Freedom met diagnostic criteria for either anxiety, alcohol

dependency, depression, or had postdeployment relationship problems. Of these numbers, only around 20% sought out treatment for mental health (Brown & Bruce, 2015). This is tied into Brown & Bruce's (2015) results – that self-stigma, public stigma, and career worry are all related to each other. Due to the stigma placed on their symptomology and concerns, these soldiers resisted seeking treatment even if it was necessary for them to effectively cope. One factor that may change the treatment effectiveness in accordance with treatment-seeking behaviors is the fear of this public stigma that an individual may hold. According to Rosenfield (1997), patients who had a stronger perspective on the existence of public stigma towards mental illness also had lower quality of life. The study reported that, despite whatever therapeutic services the individuals may have been participating in, there was a lower quality of life correlated with a higher belief of public stigma (Rosenfield, 1997).

While the worry of stigma, and the presence of self-stigma can impact a person's willingness to seek treatment in the first place, there is also a risk of hindered effects for people already in treatment. Owen et al. (2013) illustrated how an individual's perception about being in therapy due to implemented public stigmas may negatively impact the doctor-patient relationship, as well as their full and honest participation in therapy. According to this study they will begin to use certain defenses to hold back information from the therapist, or to present themselves in a way they deem to be more positive (Owen et al., 2013). One of the most crucial aspects of effective therapeutic treatment is the relationship between the client and the therapist. This relationship works to establish trust so as to improve the many aspects that go into a treatment plan. The therapist and the client work in unison to establish goals for therapy, and work to determine the best

methods to reach those goals (Bordin, 1979). If that relationship is in any way compromised, the treatment efficacy itself may also be compromised. The client may be hesitant to provide honest answers to questions from the therapist, may not put forth the best amount of effort during sessions, and may not do extra work towards therapeutic goals outside of sessions (Owen et al., 2013).

Implications of Mental Illness

Although there are many different psychological disorders which are prevalent throughout society, the most predominant and well-known ones are depression, bipolar disorder, anxiety, and a variety of other psychotic disorders. These are the most rampant disorders and impact a large amount of people regularly. Depression alone was estimated to have cost the United States 83.1 billion dollars in 2000, measured by workplace error and mortality costs due to suicides (Greenberg, Kessler, Birnbaum, Leong, Lowe, Berglund, & Corey-Lisle, 2003). According to this study, both depression rates and treatment-seeking behaviors have increased. Although more individuals seem to be attempting to get therapeutic help for their condition, these costs remain. It can be inferred from this information that the treatment options that are available and regularly pursued are insufficient or are in some way impeded.

Depression, one of the most prevalent disorders affecting the human brain, is characterized by a variety of symptoms. To be diagnosed with depression, one must display a depressed mood or loss of interest in activities, irritability, weight and appetite change, change in sleep patterns, loss of energy, inability to concentrate, and persistent thoughts of suicide (Diagnostic Criteria for Depressive Disorders). To be diagnosed with depression, an individual must meet these standards of symptoms and also have a loss of

control and functioning in their everyday life. They tend to miss school or work, have heightened levels of stress and end up isolating themselves. This symptomology can lead to them becoming closed off and resistant to talking to peers or family, and can even lead them to partake in self-injurious behaviors (Diagnostic Criteria for Depressive Disorders).

Another very common disorder affecting mental health is anxiety. Although many people experience anxious episodes during times of high stress, an individual must display at least three symptoms described in the DSM-V. These symptoms include, but are not limited to, fatigue, restlessness, difficulty concentrating, and irritability (DSM-V). Again, one of the main aspects that characterizes anxiety as a disorder for someone is its disruptiveness and intrusiveness on everyday life functioning. Today, anxiety disorders impact about 40 million Americans over the age of 18 and are typically comorbid with other psychological problems and disorders (Anxiety Disorders).

The third prevalent disorder impacting many individuals is bipolar disorder, which is also known as manic depression. Bipolar I is characterized by having one or more manic or mixed episodes, and Bipolar II disorder is characterized by having at least one hypomanic episode and/or one or more major depressive episodes. Manic episodes are characterized by heightened elation, feelings of grandiose, and excessive energy. The depressive episodes are the exact opposite, with extreme fatigue, lethargy, and apathy. Manic depression, in the most simple of terms, is swinging from high highs to very low lows. It is disruptive on the psyche and impairs judgment and functioning of the individual suffering, risking suicide attempts and death (DSM-V).

There is a recorded prevalence of mental illness throughout the United States, and those illnesses are not limited to just the ones mentioned above. With 18.5% of the population in America experiencing some mental illness in a given year (Mental Health by the Numbers), treatment seeking behaviors need to be consistent and persistent in order to alleviate symptomology and psychological distress. Public stigma and self-stigma are factors which could negatively impact those treatment seeking and treatment-compliant behaviors.

Perceived Social Support

It is a commonly understood fact that an individual's family or social group can highly influence their behavior, beliefs, and personality. Environment is said to be very significant in determining values, and family members along with peers are very big parts of a person's environment. From a very young age, an individual is essentially shaped by those they spend the majority of their time with. The way they talk, the way they interact, the attachments they make, and many other factors are strongly influenced by family and peers that are around that individual the most.

While the family can act as a positive support system for an individual experiencing mental illness, it may also further create a negative, stigmatizing atmosphere. This can be due to many reasons: fatigue from care for the family member impacted by mental illness, a lack of resources or sufficient information on how to cope, both of which can lead to a belief that recovery may not be plausible (de Sousa, Marques, Curral, & Queiros, 2012). Despite this fact that was explored in their study, de Sousa et al. (2012) found that relatives of individuals with a mental illness tended to show a very low frequency of attitudes of discrimination and stigmatization and a higher frequency of

attitudes of protection, closeness, and willingness to help and assist. They also displayed lower levels of perceived dangerousness, which was consistent with previous studies that they cited in their own research. While families in the study conducted by de Sousa et al. (2012) showed the highest levels of support and willingness to help, they did believe that medication was essential for a successful therapeutic treatment, regardless of whether or not it was against the wishes of the patient. This tendency for the family to be willingly and positively involved has changed significantly since earlier psychological and psychiatric practice. During those times, family members were reluctant and refused to get involved in any patient care. They attempted to remain emotionally distant, so as not to take on any burden of the individual's illness (Hasson-Ohayon, Levy, Kravetz, Vollanski-Narkis, & Roe, 2011). The current study is inferring from this information, as well as this change in family attitude, that more familial support is positively correlated with less of a stigmatizing attitude toward mental illness.

Peer and familial relationships appear to play a significant role in the recovery of those with a mental illness. According to various research already conducted, it can either be beneficial or detrimental to recovery. Some studies suggest that it can lead to feelings of over-dependency on others, as well as powerlessness (Barrera, 1986). Also, family members or peers can become fatigued and overwhelmed due to the burden of caring for someone with a serious mental illness. Some mental illness symptomology can lead to distress and impairments in interpersonal relationships, but a healthy and balanced support system can be extremely beneficial to both the patient and their loved one. A balanced peer-group and social network can lead to feelings of self-worth, self-efficacy, and belonging (Bracke, Christiaens, & Verhaeghe, 2008). The study conducted by Bracke

et al. (2008) also concluded that their findings coincided with much of the previous research – that an individual's social group is extremely important for their well-being throughout treatment and recovery.

Perceived social support can come from multiple outlets in a person's everyday life. It can come from their direct family members, their peers, their coworkers, their therapist or doctor, and anyone else they may interact with regularly. It was concluded in Thomas, Muralidharan, Medoff, & Drapalski's (2016) study that perceived social support had a strong positive correlation with both objective and subjective recovery. This means that having more stable and positive relationships can equate to better general functioning, less negative symptomology, and a lesser chance of relapse (Thomas et al., 2016). Since feelings of self-efficacy seem to be closely correlated with positive peer relationships, therapeutic methods should also aim to improve familial understanding about the disorder, as well as developing other supportive relationships (Thomas et al., 2016).

It can be assumed that more support provided by family members and peers can lead to a more open, accepting, and positive environment. Being able to express any sort of thought or problem freely could potentially also mean lesser chances of social distancing, self-stigma, and stigma. Close peer relationships can seek to improve the quality of life for those with some sort of mental illness, but it could also potentially lessen the chance of an individual to be susceptible to misinformation regarding what to expect from the mentally ill.

Proximity to Those with a Disorder

Thus far, there is scant research that has been done surrounding how previous contact and proximity to those with a mental illness may impact stigma. Proximity to an individual with a disorder can occur in a multitude of ways. This can mean a family member, a friend, a coworker, or the like. This can also mean viewing depictions of mental illness on television, in movies, in books, and just hearing about it via peers. Numerous studies have illustrated an inverse relationship between proximity and stigma (Corrigan, Edwards, Green, Diwan, & Penn, 2001). One study that exists was conducted in Nigeria by Ogedengeb (1993) and looked at the impact of previous contact with an impacted individual on beliefs of a mental illness being possible to overcome or not. This study found that 75% of participants who reported having proximity to an individual with a mental illness, or some sort of familiarity with mental illness, believed that the illness was recoverable, and displayed less of a negative stigma towards the illness. The study conducted by Corrigan et al. (2001) concluded with the same findings. Their hypothesis was supported in that individuals who had a closer proximity to someone with mental illness were less likely to hold stigmatizing attitudes and display prejudice towards those with such an affliction.

Stigma may also be decreased through more socialization and contact with those with a mental illness. Desforges, Lord, Ramsey, Mason, Van Leeuwen, West, & Lepper (1991) conducted a study in which participants were measured on beliefs surrounding the mentally ill both prior to and after contact with them. This study found that even if the participant initially had very stereotypical beliefs regarding mental illness at the beginning of the study, their negative beliefs transformed into more positive ones due to

conversation and interaction with a former mental patient. After the study concluded, the participants also formed more positive beliefs and ideas about mental illness and the mentally ill as a whole compared to what they thought before their interaction (Desforges et al., 1991). This shows how more contact can lead to greater understanding, less ignorance, and more acceptance which can serve to decrease instances of stigmatization.

One theory that exists to explain these findings is the Contact Hypothesis, proposed by Gordon Allport in 1954. This theory suggests that when members of different groups have consistent contact or familiarity with one another, prejudiced attitudes decrease and acceptance and understanding increase (Anagnostopoulos & Hantzi, 2011). There are a couple of different factors that impact this acceptance and cooperation. These include, but are not limited to, working towards a common goal, support from an authority figure, and close interpersonal relationships (Anagnostopoulos & Hantzi, 2011). Increased contact, such as is explained by Allport's theory, typically occurs between those who are around each other on a consistent basis. It can be inferred that those who would be more familiar with a mental illness would be a patient's family members, friends, coworkers, romantic interests, and other professional colleagues. This can serve to be a potential explanation as to why such findings exist: more contact and more familiarity with a close interpersonal relationship could potentially lead to greater understanding as well as increased support, and thus less of a chance for negative and unfounded beliefs. Anagnostopoulos and Hantzi's (2011) study found that intergroup contact typically leads to more empathetic feelings, perspective-taking, less anxiety, and improved attitudes as a whole toward the mentally ill.

Help-Seeking Behavior

While the stigmas surrounding mental health have been statistically proven to hinder seeking out appropriate professional help for certain symptoms or disorders, it may also be true that a more positive attitude towards seeking out help may be correlated with a decreased tendency to stigmatize. It has been theorized many times that those struggling with mental health problems may be more reluctant to seek out professional help, as it would be an admission of losing some semblance of control (Talebi, Matheson, & Anisman, 2016). Although rates of mental illnesses such as depression remain as high and as prevalent as ever, the American College Health Association (2008) reports that only one in four students at university age receive treatment for diagnosed depressive disorders. And this statistic is only for depression – there are many other illnesses that may go both undiagnosed and untreated, which could potentially lead to a worsening of symptoms and quality of life.

Mental illness and topics surrounding mental health are both viewed and treated very differently across cultures. Even within a culture, the way a medical practitioner views mental illness may be completely different to the way an individual with symptoms of depression views it. This concept is called an explanatory model, and is an individual's perception of how a mental illness is experienced – from where it originates, how it progresses, how it has a direct impact on their everyday functioning and life, and the way they would determine to seek out help (Kleinman, 1980). A person's explanatory model develops over time due to their societal influences and experiences with mental illness and the discussion around it. The difference between an explanatory model that a therapist and a patient may hold can negatively hinder efficient treatment (Petkari, 2015).

For example, if an individual seeking out treatment holds self-stigmas about their disorder, they may be reluctant to giving honest answers to the therapist. The therapist on the other hand expects and needs certain explicit answers in order to ensure the best and most adequate treatment plan.

Help-seeking behaviors can be correlated with self-efficacy, which is impacted by both public and self-stigma (Andersson, Moore, Hensing, Krantz, & Staland-Nyman, 2014). This stigma or fear of judgment further stops people from seeking out appropriate help for their ailments (Corrigan, 2004). Although public and self-stigmas play a crucial role in deterring people from seeking out appropriate treatment, help-seeking can be seen as unfavorable in and of itself. This is because society places great emphasis on being self-sufficient, and seeking out help from others contradicts that (Vogel, Wade, & Ascheman, 2009). Gangi, Yuen, Levine, & McNally (2016) found that individuals who utilized a biological explanation for mental illness (i.e., their symptoms were biological in nature and not in their direct control) had a lowered rate of a stigma around help-seeking. Because of this, they reported to be more willing to seek out help from a therapist. The current study infers from the previous literature that those with higher self-seeking behaviors will concurrently have lower levels of stigmas surrounding mental illness. They feel confident and secure in seeking out help, because they do not hold the beliefs that mental illness symptomology should be shameful or hidden.

Hypotheses

The previous research that has been conducted on mental illness stigma in general seems to indicate that stigma has a very significant impact on the lives of people struggling with mental illness. As the research indicates, there are multiple factors that both impact and are impacted by stigma. These factors are perceived social support, proximity to a mental illness, and help-seeking behavior. The trends in previous research findings show that each of these have a significant relationship with stigma. Based on what such studies have shown, the current study hypothesizes three things: 1) those with higher perceived social support, as indicated by results on the FES, will have lower rates of stigma regarding mental illness, 2) those with a closer proximity to somebody with a mental illness with have lower rates of stigma, and 3) those with a higher measure of help-seeking behavior will have lower rates of stigma.

Chapter III

Method

Participants

Participants included 203 male and female undergraduate students from psychology courses at Eastern Kentucky University. They were given outside activity course credit for their participation in this study. Participants were recruited through the EKU SONA system.

Materials

The survey included questions from four different scales which asked questions related to the different aspects being observed in this study: perceived social support, proximity to a mental illness, help-seeking behavior, and mental illness stigma.

Perceived Social Support.

The Family Environment Scale (FES) will be used to assess perceived social support. The FES is a 90-question inventory which consists of 10 subscales, all which measure familial social environments. The questions are in True/False form and assess how an individual feels about their own personal family environment. This includes the preferred, the expected, and the actual environment which an individual is in. The subscales measure three different dimensions of the family environment: family relationship, personal growth, and system maintenance and change. The dimension surrounding relationships measures cohesion, expressiveness, and conflict. Cohesion in this dimension is how supportive family members are of one another, expressiveness is how open family members feel in expressing their feelings and opinions, and conflict is how much anger exists openly among members of the family. The personal growth

dimension assesses independence, achievement orientation, intellectual-cultural orientation, active-recreational orientation, and moral-religious emphasis. The system maintenance and change dimension assesses both organization and control (Moos & Moos, 2009).

Proximity

The Level-of-Contact Report is an 11-item questionnaire developed by Holmes, Corrigan, Williams, Canar, & Kubiak (1999). The questionnaire lists 12 different scenarios regarding an individual's closeness or experience to a mental illness. Holmes et al. (1999) utilized other similar scales in order to create the Level-of-Contact Report to more accurately measure proximity and how much contact one has with mental illness. These questions that attempt to measure contact are in a "Yes/No" format and ask participants things such as "I have observed, in passing, a person I believe may have had a mental illness," "I have a mental illness," and "I have a relative who has a mental illness" (Holmes et al., 1999).

Help-Seeking Behavior

Attitudes Toward Seeking Professional Help is a 10-item Likert-type scale (3 = Agree, 0 = Disagree, with items 2, 4, 8, 9, and 10 being reverse scored) that is used to measure an individual's willingness to seek out help regarding mental illness (Fischer & Farina, 1999). Higher scores indicate a more positive attitude toward looking for help for mental health problems, while lower scores indicate a negative attitude. Statements include "I might want to have psychological counseling in the future" and "Personal and emotional troubles, like many things, tend to work out by themselves."

Mental Illness Stigma

The Day's Mental Illness Stigma Scale is a 28-item Likert-type scale that measures 7 different factors regarding attitudes toward people with mental illness. These 7 factors are interpersonal anxiety, relationship disruption, poor hygiene, visibility, treatability, professional efficacy, and recovery (Day, Edgren, & Eshleman, 2007). This scale was developed in order to study the general public's beliefs about mental illness. Three illnesses are focused on in this scale: bipolar disorder, depression, and schizophrenia (Day, Edgren, & Eshleman, 2007). Participants are to answer questions on a scale from strongly disagree (SD) to strongly agree (SA). For example, a participant would be asked how much they agree with the statement "the mentally ill should be isolated from the rest of the community."

Procedure

Participants completed the 90-item Family Environment Scale to determine their perceived level of social support in their environment. They answered the "True/False" questions to better measure how they perceive their family dynamic to be. The participants then completed the Level-of-Contact report, selecting "Yes/No" to various questions regarding their familiarity and experience with mental illness – have they seen it in a movie, do they have a relative with a mental illness, or do they have no experience with it? They then completed the Attitudes Towards Seeking Professional Help scale, indicating how likely or unlikely they are to reach out for help regarding mental health issues. Lastly, they completed the Day's Mental Illness Stigma scale to determine what beliefs they hold regarding mental illness. This scale helped to measure whether or not they hold negative beliefs regarding the mentally ill and the factors surrounding a mental

illness. The data collected from these four scales were then analyzed to determine if social support, proximity, and help-seeking behavior are significant predictors of mental illness stigma.

CHAPTER IV

RESULTS

The current study examined the effects of three predictors – perceived social support, proximity, and help-seeking behavior – on mental illness stigma. The study used a multiple regression analysis to analyze the relationships between these variables. Eastern Kentucky University psychology students were included as participants in this study (N = 203, 143 females, 58 males). Participants indicated their age on the survey by checking the appropriate category: 1% were 17 or younger, 61.1% were 18-20, 26.6% were 21-29, 7.9% were 30-39, 3% were 40-49, and 0.5% were 50-59.

The Day's Mental Illness Stigma Scale was used to capture scores regarding how much the participants stigmatize mental illness. The total score on the Day's Mental Illness Stigma Scale was used to determine the relationships with each independent variable. The means and standard deviations for each item can be found in Table 1.

Table 1

Items, Means, and Standard Deviations for the Day's Mental Illness Stigma Scale

Item Name	Mean	Standard Deviation
There are effective medications for mental illnesses that allow people to return to normal and productive lives.	5.23	1.27
I don't think that it is possible to have a normal relationship with someone with a mental illness.	2.44	1.63

Table 1 (continued)

Item Name	Mean	Standard Deviation
I would find it difficult to trust someone with a mental illness.	2.52	1.57
People with mental illnesses tend to neglect their appearance.	2.64	1.43
It would be difficult to have a close meaningful relationship with someone with a mental illness.	2.36	1.49
I feel anxious and uncomfortable when I'm around someone with a mental illness.	2.04	1.38
It is easy for me to recognize the symptoms of mental illnesses.	4.23	1.47
There are no effective treatments for mental illnesses.	6.08	1.26
I probably wouldn't know that someone has a mental illness unless I was told.	4.91	1.42
A close relationship with someone with a mental illness would be like living on an emotional roller coaster.	3.11	1.50
There is little that can be done to control the symptoms of mental illness.	5.66	1.29
I think that a personal relationship with someone with a mental illness would be too demanding.	2.57	1.47
Once someone develops a mental illness, he or she will never recover.	4.59	1.46
People with mental illnesses ignore their hygiene, such as bathing and using deodorant.	2.31	1.38
Mental illnesses prevent people from having normal relationships with others.	2.64	1.43

Table 1 (continued)

Item Name	Mean	Standard Deviation
I tend to feel anxious and nervous when I am around someone with a mental illness.	2.17	1.47
When talking with someone with a mental illness, I worry that I might say something that will upset him or her.	3.54	1.61
I can tell that someone has a mental illness by the way he or she acts.	3.62	1.46
People with mental illnesses do not groom themselves properly.	2.27	1.36
People with mental illnesses will remain ill for the rest of their lives.	5.31	1.49
I don't think that I can really relax and be myself when I'm around someone with a mental illness.	2.32	1.52
When I am around someone with a mental illness I worry that he or she might harm me physically.	2.04	1.26
Psychiatrists and psychologists have the knowledge and skills needed to effectively treat mental illnesses.	5.22	1.42
I would feel unsure about what to say or do if I were around someone with a mental illness.	2.46	1.40
Mental health professionals, such as psychiatrists and psychologists, can provide effective treatments for mental illnesses.	5.26	1.44

The 90-item FES was used to test the first hypothesis indicating that a higher measure of perceived social support would correlate with a lower rate of stigma. Table 2 shows the percentage of participants who indicated "true" for each item on the FES. To be able to analyze the scores for each subscale and how they correlate with stigma, composite variables were formed by computing new variables based on what each item

was specifically measuring. This was done in accordance with the FES scoring manual given with the items. Specific items are meant to measure and lead to scoring of specific subscales in the scale, and some items were to be reverse scored as described in the FES manual. All correlations between the subscales and stigma were nonsignificant, $p > .05$ (see Table 3).

Table 2

Individual Item Response Frequencies for the Family Environment Scale

Item Name	Percentage that selected "True"
Family members really help and support one another.	87%
Family members often keep their feelings to themselves.	39%
We fight a lot in our family.	30%
We don't do things on our own very often in our family.	28%
We feel it is important to be the best at whatever you do.	76%
We often talk about political and social problems.	60%
We spend most weekends and evenings at home.	62%
Family members attend church, synagogue, or Sunday School fairly often.	51%
Activities in our family are pretty carefully planned.	46%
Family members are rarely ordered around.	61%
We often seem to be killing time at home.	49%
We say anything we want to around home.	56%
Family members rarely become openly angry.	50%
In our family, we are strongly encouraged to be independent.	83%

Table 2 (continued)

Item Name	Percentage that selected "True"
Getting ahead in life is very important in our family.	79%
We rarely go to lectures, plays or concerts.	56%
Friends often come over for dinner or to visit.	53%
We don't say prayers in our family.	29%
We are generally very neat and orderly.	67%
There are very few rules to follow in our family.	51%
We put a lot of energy into what we do at home.	65%
It's hard to "blow off steam" at home without upsetting somebody.	40%
Family members sometimes get so angry they throw things.	18%
We think things out for ourselves in our family.	70%
How much money a person makes is not very important to us.	73%
Learning about new and different things is very important in our family.	79%
Nobody in our family is active in sports, Little League, bowling, etc.	31%
We often talk about the religious meaning of Christmas, Passover, or other holidays.	57%
It's often hard to find things when you need them in our household.	25%
There is one family members who makes most of the decisions.	54%
There is a feeling of togetherness in our family.	75%
We tell each other about our personal problems.	70%
Family members hardly ever lose their tempers.	51%
We come and go as we want to in our family.	70%
We believe in competition and "may the best man win."	51%
We are not that interested in cultural activities.	38%
We often go to the movies, sports events, camping, etc.	60%

Table 2 (continued)

Item Name	Percentage that selected "True"
We don't believe in heaven or hell.	11%
Being on time is very important in our family.	73%
There are set ways of doing things at home.	63%
We rarely volunteer when something has to be done at home.	30%
If we feel like doing something on the spur of the moment we often just pick up and go.	68%
Family members often criticize each other.	37%
There is very little privacy in our family.	36%
We always strive to do things just a little better the next time.	81%
We rarely have intellectual discussions.	26%
Everyone in our family has a hobby or two.	75%
Family members have strict ideas about what is right and wrong.	69%
People change their minds often in our family.	50%
There is a strong emphasis on following rules in our family.	62%
Family members really back each other up.	72%
Someone usually gets upset if you complain in our family.	34%
Family members sometimes hit each other.	16%
Family members almost always rely on themselves when a problem comes up.	43%
Family members rarely worry about job promotions, school grades, etc.	24%
Someone in our family plays a musical instrument.	55%
Family members are not very involved in recreational activities outside work or school.	29%
We believe there are some things you just have to take on faith.	75%

Table 2 (continued)

Item Name	Percentage that selected "True"
Family members make sure their rooms are neat.	52%
Everyone has an equal say in family decisions.	55%
There is very little group spirit in our family.	24%
Money and paying bills is openly talked about in our family.	66%
If there's a disagreement in our family, we try hard to smooth things over and keep the peace.	71%
Family members strongly encourage each other to stand up for their rights.	79%
In our family, we don't try that hard to succeed.	19%
Family members often go to the library.	36%
Family members sometimes attend courses or take lessons for some hobby or interest (outside of school).	46%
In our family each person has different ideas about what is right and wrong.	53%
Each person's duties are clearly defined in our family.	55%
We can do whatever we want to in our family.	41%
We really get along well with each other.	75%
We are usually careful about what we say to each other.	52%
Family members often try to one-up or outdo each other.	26%
It's hard to be by yourself without hurting someone's feelings in our household.	25%
"Work before play" is the rule in our family.	67%
Watching TV is more important than reading in our family.	49%
Family members go out a lot.	54%
The Bible is a very important book in our home.	60%
Money is not handled very carefully in our family.	21%
Rules are pretty inflexible in our household.	38%
There is plenty of time and attention for everyone in our family.	69%

Table 2 (continued)

Item Name	Percentage that selected "True"
There are a lot of spontaneous discussions in our family.	77%
In our family, we believe you don't ever get anywhere by raising your voice.	51%
We are not really encouraged to speak up for ourselves in our family.	21%
Family members are often compared with others as to how well they are doing at work or school.	38%
Family members really like music, art and literature.	68%
Our main form of entertainment is watching TV or listening to the radio.	67%
Family members believe that if you sin you will be punished.	53%
Dishes are usually done immediately after eating.	46%
You can't get away with much in our family.	53%

Table 3

Bivariate Correlations between Stigma Scores, Family Environment Subscale Scores, Level-of-Contact Scores, and Help-Seeking Behavior Scores

	1	2	3	4	5	6	7	8	9	10	11	12
1. COH												
2. EXP	.62**											
3. CON	-.62**	-.53**										
4. IND	.47**	.46**	-.48**									
5. AO	.15**	-.00	.04	.06								
6. ICO	.51**	.44**	-.29**	.25**	.08							
7. ARO	.57**	.41**	-.27**	.30**	.20**	.54**						
8. ORG	.32**	.14	-.29**	.21**	.26**	.11	.27**					
9. CTRL	-.30**	-.53**	.36**	-.34**	.26**	-.13	-.15*	.14				
10. PROX	-.01	.02	.02	.01	-.02	-.18*	-.01	.19**	-.10			
11. STIG	.05	.02	-.06	-.01	.09	-.02	.11	.13	.05	.22**		
12. HS	.19**	.18*	-.21**	.24**	.03	.13	.05	.02	-.13	-.28**	-.04	
Mean	6.69	5.88	2.84	6.56	5.78	5.42	5.11	5.67	4.55	15.86	95.50	21.42
SD	2.35	2.26	2.44	1.53	1.72	2.34	2.24	2.09	2.28	2.25	14.95	5.35
A											.79	.63

Note. COH=cohesion, EXP=expressiveness, CON=conflict, IND=independence, AO=achievement orientation, ICO=intellectual-cultural orientation, ARO=active-recreational orientation, ORG=organization, CTRL=control, PROX=proximity, STIG=stigma, HS=help-seeking behavior.

The second hypothesis that a higher level of proximity to those with a mental illness would correlate with a lower level of stigma was not supported by the data. The total score from each participant's Level-of-Contact Report was used to analyze the relationship with stigma. The frequencies of those who selected "Yes" for items on this measure can be found in Table 4. In contradiction to this hypothesis, those with a higher level of proximity to those with a mental illness have a higher level of stigma, $r = .22$, $p = .003$. It should also be noted that those with a higher level of proximity also have a higher level of help-seeking behavior, $r = .25$, $p = .000$ (Table 3).

Table 4

Individual Item Response Frequencies for the Level-of-Contact Report

Item Name	**Percentage that selected "Yes"**
I have watched a movie or television show in which a character depicted a person with a mental illness.	91%
My job involves providing services/treatment for persons with a mental illness.	23%
I have observed, in passing, a person I believe may have had a mental illness.	89%
I have observed persons with a mental illness on a frequent basis.	62%
I have a mental illness.	30%
I have worked with a person who had a mental illness at my place of employment.	51%
I have never observed a person that I was aware had a mental illness.	79%
A friend of the family had a mental illness.	66%

Table 4 (continued)

Item Name	Percentage that selected "Yes"
I have a relative who has a mental illness.	65%
I have watched a documentary on the television about mental illness.	22%
I live with a person who has a mental illness.	30%

The third hypothesis theorizing that those who have a more positive attitude toward seeking professional help would also have a lower instance of stigma was not supported by the data. The composite variable for this measure was formed by taking an average of all scores from the items. The mean and standard deviation of each item on this scale can be found in Table 5. As can be seen in Table 3, there was no significant correlation between help-seeking behavior and stigma.

Table 5

Items, Means, and Standard Deviations for the Attitudes Toward Seeking Professional Help Scale

Item Name	Mean	Standard Deviation
If I believed I was having a mental breakdown, my first inclination would be to get professional attention.	2.64	1.11
The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.	1.55	1.03
If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.	2.87	1.02

Table 5 (continued)

Item Name	Mean	Standard Deviation
There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.	1.49	1.40
I would want to get psychological help if I were worried or upset for a long period of time.	3.13	.95
I might want to have psychological counseling in the future.	2.71	1.09
A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.	2.87	.92
Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.	1.39	1.16
A person should work out his or her own problems; getting psychological counseling would be a last resort.	1.45	1.05
Personal and emotional troubles, like many things, tend to work out by themselves.	1.24	1.05

A simultaneous multiple regression analysis was conducted using scores on the Family Environment Scale, Level-of-Contact Report, and Attitudes Toward Seeking Professional Help scale as predictors for scores on the Day's Mental Illness Stigma Scale. No significant predictors were found. Table 6 shows all B-weights for the predictor variables.

Table 6

Results of Regression Analysis for the effect of Predictor Variables on Stigma.

Variable	Stigma B
Cohesion	-.77
Expressiveness	.38
Conflict	-1.03
Independence	-1.20
Achievement Orientation	.62
Intellectual-Cultural Orientation	.01
Active-Recreational Orientation	.88
Organization	.13
Control	.46
Proximity	1.98
Help-Seeking Behavior	.20
R^2	.11
F	1.58

Note. **p* < .05 ***p* < .01

CHAPTER V

DISCUSSION

Whether stigma generates from one's own perspective and knowledge about mental illness, or from what they hear others express about it, it can be undeniably detrimental to an individual's treatment and wellbeing (Hinshaw & Stier, 2008). It can produce feelings of fear, shame, and a sense of failure that can deter many people from being open about the help they need. There are many stigmas surrounding mental illness that can be seen in all aspects of everyday life – on television, in movies, in books, and in conversation. The mentally ill are depicted as dangerous, delusional, and untrustworthy. These depictions are dangerous when they become more prevalent, because they only feed into the shame many may already feel about their sufferings. Although treatment methods have improved substantially over recent years, two-thirds of people with a diagnosed disorder do not seek out treatment for their symptoms (U.S. Department of Health and Human Services, 1999). One of the most predominant reasons that people reject help and therapy is stigma (Scheffer, 2003).

Review of Hypotheses and Findings

The current study sought to explore how various aspects of one's life may predict their level of stigmatization of mental illness. Specifically, the predictors of perceived social support in the family environment, personal proximity to mental illness, and one's willingness to seek out help were analyzed to test their effects on the tendency to stigmatize those with mental illness. The results of the current study illustrated that although social support and help-seeking behavior do not predict stigma, a closer proximity to mental illness does predict an increased tendency to. It should also be noted

that those with a closer proximity to a mental illness have higher levels of help-seeking behavior.

Regarding perceived social support, this study could not determine that such support is a significant predictor of mental illness stigma. Although it was originally theorized that higher social support may correlate with lower instances of internalizing stigma due to feelings of support and acceptance, this was not confirmed by the research outcomes. There is an ample amount of research suggesting that having higher levels of perceived social support reduces the impact that a stigma may have on those with a mental illness (Thoits, 2011). Research also suggests that having stronger social relationships and support surrounding a mental illness reduces the instances of self-stigma (Denenny, Thompson, Pitts, & Dixon, 2015). It was originally inferred from previous findings suggesting that feeling supported may reduce negative attitudes toward such afflictions, but this theory was not supported by the current data.

It was originally theorized that higher rates of proximity to mental illness would predict lower rates of stigmatization. This hypothesis was not supported by the data. The data showed that those with higher rates of proximity actually tend to stigmatize more. One possible explanation for this finding is that individuals with a closer proximity to a mental illness (i.e., their sibling or friend at school displays symptoms of one) are more likely to consistently see the negative emotion and behaviors associated with it. These individuals may be more likely to internalize the negative beliefs surrounding mental illness and stigmatize due to fear of one day developing a disorder themselves. De Sousa et al. (2012) noted that those who are in persistent direct contact with the mentally ill individual – specifically those who were helping to give care to them – experience

multiple negative impacts associated with their caregiving. Those close to an individual with a mental illness may also lack sufficient resources for information regarding that illness, thus preventing them from having a full awareness of what they may be witnessing (de Sousa et al., 2012).

Another potential explanation for this finding is the concept of "courtesy" stigma, which explains that family members of those with a mental illness are also discriminated against based on their proximity to the mentally ill (Wahl & Harman, 1989). If they face the same sort of prejudice and discrimination that the mentally ill individual does, they may also tend to internalize stigma and believe public stigmas more. Wahl and Harman (1989) have shown that some family members experience more distant social relationships due to their relationship with a mentally ill individual. These strained social relationships may allow the family member to focus more on the negative attributes of the individual's illness, thus leading to higher instances of stigmatization.

A person's willingness to seek out help did not significantly predict their tendency to hold stigmas about mental illness. This coincides with findings by Andersson et al. (2014) stating that although self-efficacy is impacted by stigma and mental illness, it does not have a significant impact on help-seeking behavior. Although help-seeking may be deterred due to stigma – and it may make matters regarding a mental disorder worse – it does not seem to be a significant predictor of stigma. Although it was not originally hypothesized, the data showed that there is a significant relationship between proximity and help-seeking behavior. According to the results, those with a higher rate of proximity to mental illness also have a higher rate of help-seeking behavior. This finding could be due to an individual witnessing how bad some symptoms may impact one's functioning.

This observation of reality could lead to a fear of becoming that ill themselves, so they seek out help very willingly when symptoms first appear.

Implications and Future Research

While the current study sought to explore the different variables that may impact stigma in order to help prevent higher instances of it in the future, it failed to find significant relationships in two of the three independent variables. It is important to note that there was statistical significance in that closer proximity also means more stigma. For future studies, the role of the family in a person's treatment needs to be further explored. While this should be explored for the patient themselves, it is important to understand the impact the illness has on those around that individual as well. If more supportive resources are given to those close to the patient, they may feel less of a negative impact on their own emotional wellbeing. Since those close to someone with a mental illness have reported feeling more fatigue and harmful effects on their own relationships, future studies should look into how to effectively increase coping mechanisms and treatment for the family members as well. Also, more resources means more understanding, which could lead to greater support of who is suffering from a disorder. This support could potentially lead to less instances of self-stigmatization and more feelings of self-efficacy and resilience.

It is important to note that although there was no significant relationship between help-seeking behavior and stigma, stigma does impact appropriate treatment. As noted in the literature review, treatment can be hindered greatly due to either the fear of stigma, the belief of public stigma, or the internalized self-stigma. While being more willing to seek out help may not accurately predict one's tendency to stigmatize, it is important to

continue to look at this relationship. Although there is an ample amount of literature on how stigma impacts help-seeking behavior, there is not much on how help-seeking behavior may reduce stigma.

There seems to be a big opportunity to expand the literature on how social support may impact stigma. Since previous literature is lacking and the current study did not provide any significant results, new studies could seek to further explore the topic. Expanding beyond the Family Environment Scale (Moos & Moos, 2009), it may be important to look at how other social relationships potentially predict the tendency to stigmatize. For example, how does perceived support from one's close friendships or romantic relationships impact attitudes toward the mentally ill?

For future consideration it may also be important to specify proximity for each individual participant. Although the Level-of-Contact Report (Holmes et al., 1999) accurately depicts one's familiarity with mental illness in general, it does not allow the participant to state how that proximity manifested. Someone who has only seen a mental illness on a television show, or someone who has a coworker that has a mental illness, may have a totally different experience of it than a relative of someone with a mental illness may have. Being around an ill family member may present a greater opportunity to witness the negative attributes that coincide with symptomology, while having an ill coworker does not. This negative experience may explain why closer proximity entails greater stigmatization. It would be important to note this distinction for future studies. It would also be beneficial to view how to effectively increase willingness to seek out help and subsequently analyze how that impacts attitudes toward mental illness. The current study may have been limited in how data was collected. Although surveys are a valuable

tool to collect data from a large participant pool in a short amount of time, they do not provide the opportunity to find detailed information about individual differences that may help to explain certain relationships (or lack thereof).

Conclusion

Stigmas surrounding mental illness are ever-prevalent throughout society today, and those stigmas threaten the successful treatment and perceived self-worth of many people dealing with a variety of disorders. Depictions in the media consistently trivialize what in reality are debilitating diseases, and these depictions wrongfully educate those who have not gotten more suitable information elsewhere; this is how many stigmas grow and continue to thrive. It seems essential that an individual feel accepted, respected, and supported in order to feel confident in their abilities to improve and gain a sense of resilience. Maintaining a positive and uplifting social atmosphere is crucial in improvement of many disorders, and that social atmosphere should be free of negative attitudes and maladaptive beliefs about mental illness. The current study suggests that there are many attributes that may increase the chance of stigma to arise, and that those factors should be studied and understood further to help decrease such beliefs. By giving help to those who may be in the role of caregiver or who see the negative impact of a mental illness, fear and subsequent rates of stigmatization may begin to dwindle.

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Appendix A:

Informed Consent Form

Consent Form

Title: The Development of Mental Illness Stigma: The Role of Perceived Family Support, Personal Experience, Social Proximity, and Help-Seeking Behavior

Introduction:

Participation in this study will include completing a series of surveys surrounding family/social life, prior experience with mental illness, help-seeking attitudes, and potentially held stigmas. Participants will give no personally identifying information and the data collected will only be handled by those running the study. Upon completion, the participant will receive .5 Sona credits for their participation.

Possible Risks:

Participants will be asked specific questions about attitudes they may hold towards those with mental illnesses. This may be potentially unpleasant for the participant if there is any negative memory associated with the subject. If a participant would like further assistance following the survey, contact information for services are listed below.

EKU psychology clinic: (859) 622-2356, www.psychology.eku.edu

EKU counseling center: (859) 622-1303

National Suicide Prevention Lifeline: 1-800-273-8255, www.suicidepreventionlifeline.org

Contact Information:

Below is contact information for the principle investigators of the study

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