THE INFLUENCE OF A MENTAL ILLNESS LABEL ON DESIRED SOCIAL DISTANCE

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By
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CERTIFICATION OF APPROVAL

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DEDICATION

I would like to dedicate this thesis to my family: my grandmother, Joyce, without whom I never would have had the drive to continue all the way through graduate school; my mom, Amber, my dad, Alex, and all of my siblings and cousins for being my constant cheerleaders; and to Niki, the best non-biological sibling that anyone could ask for. Your support means everything to me.

Finally, I would like to dedicate this thesis the teacher who introduced me to psychology in the first place. Fredericksen, this is all your fault, and I couldn't be more thankful.

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ABSTRACT

This study looked at the influence that a mental illness label has on the amount of social distance desired from a person with a mental illness. Participants were 480 (265 male, 212 female, 1 transgender, and 2 non-binary) individuals over the age of 18 in the United States. Participants answered questionnaires that assessed their willingness to interact with, and their emotional reactions toward, a person described in a vignette. They also completed questionnaires that assessed the participant's familiarity with mental illness and their tendency to answer questions in socially acceptable ways. Results showed there was a significant difference in desired social distance between individuals labeled with an Anxiety Disorder and individuals labeled with Bipolar Disorder, and between individuals labeled as having Schizophrenia and individuals labeled as having "Mental Illness" and those labeled as having Anxiety. Perceived dangerousness, familiarity with mental illness, and social desirability were all shown to be significant predictors of desired social distance.

CHAPTER I

INTRODUCTION

"Mental illness and hatred pulls the trigger, not the gun." This statement was given by Donald Trump in August of 2019 in response to the mass shooting that had taken place at Stoneman Douglas High School in Parkland, Florida, in which 17 people were killed. This statement, and many others like it, have been played on news stations across the country, and place the blame for violent tragedies on individuals with mental illness. When statements like these are presented in the media, they add to the negative views that people may already have about mental illness and, therefore, contribute to the stigma that individuals with mental illness already face (Wilson et al, 2016).

Stigma

Stigma, is defined as an "attribute which is deeply discrediting" (Goffman, p.3) and marks an individual as being "deviant, flawed... or generally undesirable" (Jones et al., p.6). It is commonly measured through assessments of stereotypes, perceived dangerousness, and behavioral responses to the stigmatized group (Link et al., p.513). The most common behavioral response is that of social rejection, which is typically measured through social distance (Yang & Link, p.3). The concept of social distance was initially defined by Robert Park in 1924 as "the grades and degrees of understanding and intimacy which characterize pre-social and social relations generally" (Park, p.339). In today's terms, social distance can be understood as how much an individual wants to avoid contact with another (Jorm & Oh, 2009). Social

distance relates to stigma in that social distance is a product of social distance. When a person is part of a stigmatized group, other people tend to be avoidant of them, thereby creating social distance.

The first measure of social distance was created by Emory Bogardus in 1925 in order to assess social distance in regards to people of different races or ethnicities (Link, et al., 2004). This measure consists of questions posing hypothetical interactions with an individual, such as "I would like this person to come and work at the same place I do" (Anderson, p.133). All items are rated on a Likert scale from "I certainly would" to "I certainly would not." Adapted versions of this scale are often used due to the dated language of the original. It remains a commonly used measure in research on mental illness stigma due to its ease of use and the tendency for stigma to manifest as social distance.

When discussing stigma, the type of stigma that is most often thought of is public stigma. Public stigma is defined as stigma that comes from other people, and can include negative opinions and stereotypes (Corrigan & Powell, p.381). Another type of stigma is self-stigma (Rüsch et al., 2009). This is defined as stigma that comes from within a person, and can be exacerbated by public-stigma. While stigma is, in many cases, unspoken, individuals who have been stigmatized do feel its effects. Studies show that stigma can lead individuals to avoid entering into the workforce or integrating themselves into society in general, which can further negative stereotypes, which can then reinforce both public and self-stigma (Corrigan & Powell, 2012). Many groups in society are stigmatized due to characteristics such as race, gender

identity, sexual orientation, and mental illness (Pescosolido, p.3). The current study will focus on mental illness.

Contributing Factors to Stigma

Social norms. There are many factors that contribute to stigma. One such factor is social norms. Social norms are the unwritten rules of society. They dictate the way people are, and are not, supposed to act in various situations (Norman, et al., p.853). For example, social norms dictate that people are supposed to face the doors when riding in an elevator, so when a person faces the wall, it can make other people in the elevator feel unsettled. Mental illnesses often violate social norms. For example, a person who is experiencing a schizophrenic episode may hear voices that others do not and may be verbally responding to those voices. To a passerby, it would look as though this individual were just talking to the air, which is not something typically considered socially appropriate. The more that a given mental illness is thought to violate social norms, the more stigmatizing it is likely to be (Norman et al, 2008).

General perceptions. The general perceptions of individuals with mental illness also influence stigma towards mental illness. General perceptions of mental illness can include stereotypes, beliefs about personal responsibility, and the etiology of the mental illness. A study done by Crisp et al (2000) assessed people's opinions of individuals with various mental illnesses. When negative opinions of the person with mental illness, such as the person being a danger to others, being hard to talk to, and having themselves to blame for their illness, were present, there was a higher desire

for social distance from those people. Personal responsibility, or the extent to which an individual has control over their condition, has been found to be a mediating factor in an increased desire for social distance from individuals with a mental illness (Feldman & Crandall, 2007).

Fear and dangerousness. In the various studies that have looked at perceptions of mental illness and how they relate to stigma, two specific perceptions seem to be the most related to stigma: perceived dangerousness (Anderson et al, 2015; Angermeyer et al., 2015; Corrigan et al., 2003; Crisp et al., 2000; Feldman & Crandall, 2007) and fear of the individual with the mental illness (Anderson et al, 2015; Angermeyer et al, 2015; Corrigan et al., 2003). Because these perceptions are, to a large degree, subjective, even commonly occurring mental illnesses may be stigmatized.

Anxiety is one such example. Most people experience normal levels of anxiety in response to stressors. But according to the National Institute of Mental Health, in the United States in 2016, 7.1% of people reported having General Anxiety Disorder, and 2.8% reported having Social Anxiety Disorder. Research done by Anderson et al. (2015) looked specifically at the stigmatization of individuals with Social Anxiety Disorder, which is characterized by fears of social situations, being scrutinized by others, and acting in a way that will be embarrassing or humiliating, in comparison to the stigmatization of individuals with Major Depressive Disorder, and individuals with Mental Illness. The study measured stigmatization through social distance. Results showed that when Social Anxiety Disorder was perceived to be

dangerous, participants desired greater social distance than they did from individuals with Major Depressive Disorder.

Similar results have been found in studies that looked at people's reactions to Bipolar Disorder and Schizophrenia. Stip, Caron and Mancini-Marie (2006) looked at the perceptions of and attitudes towards individuals with Bipolar Disorder where the majority of participants indicated a belief that individuals with Bipolar Disorder were dangerous: 46% said they were "slightly dangerous," 24% said they were "quite dangerous," and 4% said they were "very dangerous" (p.162). Moreover, Ellison Mason, and Scior (2014) found that when participants had a fear response towards individuals with Bipolar Disorder, there was an increased desire for social distance.

Stip, et al (2006) also looked at opinions of and attitudes toward Schizophrenia. Participants in this study tended to rate individuals with Schizophrenia as being dangerous. Angermeyer, Daubmann, Wegscheider, Mnich, Schomerus, and von dem Knesebeck (2015) conducted a study to see whether biogenetic attributions for Schizophrenia had any effect on the amount of social distance desired from an individual with the disorder. When participants believed that Schizophrenia occurred due to biogenetic causes, there was an increased desire for social distance, as well as an increased fear response. Researchers suggested that this increase in fear could have been evoked by ascribing Schizophrenia to a brain disease.

Labels

Labels are often the first things that people use when they disclose information about themselves. Because of mental heuristics, or mental short cuts, snap judgements can be made based solely on the label that a person hears (Kuklinski & Quirk, p.156). When a label brings up negative associations, that can result in an increased desire to be socially distant (Szeto, et al., 2013).

Labels can cause an increased desire for social distance. This phenomenon has been seen in various populations in society. For example, people who have been convicted of a felony are labeled as felons, and often face stigma in employment- and housing-seeking situations.

When it comes to mental illness, labels have been found to matter as well. Jorm and Oh (2009) found that there is a greater desire for social distance when a person has a general label of having a "mental illness" than when that person is labelled as having a physical illness, or not having any label at all. Additionally, Martinez, Piff, Mendoza-Denton, and Hinshaw (2011) found that participants desired greater social distance from individuals who were labeled as having a mental illness– whether or not it was a general label such as "mental illness" or a specific label, such as "depression"– than from individuals who were labeled as having a physical illness.

Familiarity and Social Rejection

While many things contributed to an increased desire for social distance, familiarity seems to be one thing that is often associated with a *decreased* desire for social distance. Corrigan, Green, Lundin, Kubian, and Penn (2001) found that when

participants had some knowledge about, or personal familiarity with, mental illness, they were less likely to fear people with mental illness. A similar study was conducted in 2011 by Anagnosoploulos and Hantzi in Greece, where they also found that participants who had more knowledge and familiarity with mental illness were less likely to fear those with mental illness.

Markowitz and Engelman (2016) also looked at how familiarity with mental illness can impact a desire for social distance. In addition to asking participants about their perceptions of the individual in the vignette they were given, researchers also asked participants to disclose their "stigma status" (p. 749). Stigma status was divided into three categories: personally having a mental illness, knowing someone with a mental illness, or having no contact with a mental illness. Results suggested that the more contact a person has with mental illness, the less social distance they desire from individuals with a mental illness.

Social Desirability

Another factor that can influence the way stigma presents is social desirability. Social desirability is the tendency to act in ways that are seen as desirable by societal standards when a person knows that someone else is going to see or hear what they say. When it comes to self-report surveys, such as those used in this study, this means that people may "fake good" answers to paint themselves in a better light (Crowne & Marlowe, 1960). It is important to take social desirability into account when looking at stigma because, while people may say things that make them seem

like they are not contributing to stigma, they may actually act in ways that contribute to stigma when they think they are not being watched in any way.

Much of the previous research on mental illness stigma uses vignettes that give detailed descriptions of symptoms of various mental illnesses in conjunction with assessments of emotional reactions, perceptions of mental illness, and desired social distance. This research is valuable in increasing the currently understanding of how mental illness is stigmatized, but it often does not take into account that descriptions of symptoms of mental illness are not typically shared when a person discloses that they have a mental illness. Most mental illnesses are invisible to observers, and so the first time a person learns that another has a mental illness, all they are told is the name of the illness. Their reactions are based on the associations that the label brings up for them. An undergraduate research study done by Hari, Soliz, McClure, Castro, Sarkis, and Williams (2017) sought to begin filling in this gap in the research by looking at the amount of social distance that was desired from individuals with a label of Depression. Participants in this study were presented with one of two vignettes: the control vignette, which only contained a few introductory statements about a hypothetical college student, and the Depression vignette, which contained the same introductory statements as the control vignette, as well as a statement that included a label of Depression. This study only gathered information about desired social distance in relation to the person described in the vignette. The study did not find any significance, but it also did not take emotional reactions,

familiarity with mental illness, and social desirability into consideration (Hari et al, 2017).

Current Study and Hypotheses

The current study is an expansion on this study and will take emotional reactions, familiarity with mental illness, and social desirability into account when looking at desired social distance in relation to individuals with a mental illness label. The Hari et al (2017) study only looked at Depression, but the current study will include other labels that are frequently seen in research on mental illness stigma. Research has compared general mental illness labels to Depression (Szeto et al, 2013), Social Anxiety Disorder to Depression (Anderson et al, 2015), Depression to Anxiety and Bipolar Disorder (Ellison et al, 2014), Schizophrenia and Depression (Angermeyer et al, 2015), and Schizophrenia and Bipolar Disorder (Stip & Mancini-Marie, 2006), but it has not combined the general "Mental Illness" label, Anxiety, Bipolar Disorder, and Schizophrenia into one study.

The current study looked at the amount of social distance desired from an individual without mental illness, one who has a general "mental illness," one with Generalized Anxiety Disorder, one with Bipolar Disorder, and one with Schizophrenia. The hypotheses of the study are as follows:

1. Participants will desire greater social distance from a person with any mental illness label– either a general "mental illness" label or a label that indicates a specific mental illness– than from a person without.

2. Participants will desire greater social distance from a person with Bipolar Disorder than from a person with Generalized Anxiety Disorder.
3. Participants will desire greater social distance from a person with Schizophrenia than from a person with Bipolar Disorder.
4. Participants who have had more contact, or have more familiarity, with mental illness will desire less social distance overall than participants who have had less contact with mental illness.

CHAPTER II

METHODS

Participants

Participants for this study were all from the United States and were recruited online through Amazon Mturk. A total of 480 (265 male, 212 female, 1 transgender, and 2 non-binary) individuals participated in this study, and were compensated $0.50 for their participation. Participants ranged in age from 19 to 76 years (M = 38.88, SD = 12.91). A majority of the participants were White (79.2%), 9.2% were Black, 5.6% were Asian, 4.8% were Latino/Latina, 0.6% were Native American/Pacific Islander, and 0.6% identified as Mixed.

Materials

Demographics

A three-item demographics questionnaire, created by me for use in this study, assessed participant's age, gender, and ethnicity. (see Appendix A).

Vignettes

Five vignettes (see Appendix B) were adapted from those used by Hari et al (2017). The vignettes were adapted by changing the name of the described individual, changing the mental illness label used in each one, and adding a short description of the named mental illness. One vignette served as the control and described a person who is not labeled as having a mental illness; one described a person who has been labeled as having a non-specific mental illness; one described a person who has been labeled as having General Anxiety Disorder; one described a person who has been

labeled as having Bipolar Disorder; and one described a person who has been labeled as having Schizophrenia. The vignettes were set up in similar ways, with the inclusion of the mental illness label and a short description being the only difference.

Social Distance

An adapted version of the Bogardus Social Distance Scale (see Appendix C) was used to assess desired social distance. Items on this measure include questions such as, "Would you have lunch with Taylor?" and "Would you recommend Taylor for a job?" This measure consists of twelve items, all of which are rated on a 6-point Likert-style Scale, with 1 being "I certainly would" and 6 being "I certainly would not." Hari et al (2017) adapted the language in the scale to make it more relevant to today's vocabulary by changing the words used. For example, the original measure used the phrase "would have as chums" (Bogardus, 1933), which was updated to say "would be friends with." Scores were averaged for each participant. Higher scores indicate higher levels of desired social distance. The scale was shown to have good internal consistency (Cronbach's $\alpha = .95$).

Familiarity

Familiarity with mental illness was assessed with the Level of Contact Report (see Appendix D), developed by Holmes, Corrigan, Williams, Canar, and Kubiak (1999). It consists of 12 statements that depict exposure to mental illness, such as "I have a relative who has a mental illness," and "A friend of the family has a mental illness." Each item has been assigned a certain number rating that was determined by a panel of experts. Participants marked all statements that apply to them. Possible

scores ranged from 1 to 12. The item with the highest rating determined the participant's score. The higher the score, the more contact with mental illness the person has had. The original measure used the term "severe mental illness." For the purposes of this study, the term "severe" has been removed due to how subjective the term is. This measure was shown to have a reliability of .83 (Holmes et al, 1999). The Level of Contact Report was shown to have good internal consistency (Cronbach's α = .92).

Emotional Reactions

Participants' emotional reactions to the individual described in the vignette were assessed using the Attributions Questionnaire (see Appendix E), developed by Corrigan (2008). This measure consists of twenty-seven items that assess participants' emotional responses on nine factors: blame, anger, pity, desire to help, dangerousness, fear, avoidance, segregation, and coercion. Items are rated on a 9-point Likert-style Scale. For each factor, a score is found by totaling the responses for each item within that factor. The higher the total score for a particular factor, the more a participant endorses it. Only the 6 items that assess fear (items 3, 19, and 24) and dangerousness (items 2, 13, and 18) were used in the analysis for this study. These items were shown to have inter-rater reliability of .86 (Brown 2008). The items assessing dangerousness were shown to have good internal consistency (Cronbach's α= .94), as were the items assessing fear (Cronbach's α = .95).

Social Desirability

Participants' social desirability was assessed using the Marlowe-Crowne Social Desirability Scale (see Appendix F), which has been shown to have a reliability score of .88 (Crowne & Marlowe, 1960). This is a 33-item measure that assesses how likely a participant is to answer questions in a way that makes them seem more desirable by society's standards. Items on this measure include statements such as, "I never hesitate to go out of my way to help someone in trouble" and "I am sometimes irritated by people who ask favors of me." A point is given for each item answered in a socially desirable way. The higher a participant's total score, the more they are considered to answer in a socially desirable way. This measure was shown to have a good internal consistency (Cronbach's $\alpha = .92$).

Design

This study was a between-subjects design. The independent variable was the use of a mental illness label and consisted of five levels: a control where there is not a mental illness label, a non-specific label of "mental illness," a label of Generalized Anxiety Disorder, a label of Bipolar Disorder, and a label of Schizophrenia, which was manipulated through the use of vignettes.

The participant variables that were tested were the participants' level of contact, or familiarity, with mental illness, and their tendency to answer in socially desirable ways. Their familiarity was tested with the Level of Contact Report. Their tendency to answer in socially desirable ways was assessed with the Marlowe-Crowne Social Desirability Scale.

The covariate that was tested was the participants' emotional reactions, specifically the perceived dangerousness of and fear response towards the person described in their assigned vignette. This was assessed using the Attributions Questionnaire.

The dependent variable was the amount of social distance the participant desires from the individual mentioned in the vignette they read. This was measured with an adapted version of the Bogardus Social Distance Scale.

Procedures

This study was conducted online via Amazon Mturk. Participants were first presented with an informed consent form. If participants did not consent, they were sent directly to the debriefing form and thanked for their time. Upon consenting to the study, they first filled out the demographics questionnaire.

Participants were then randomly assigned to read one of the five vignettes. They then completed the social distance questionnaire while thinking about the individual described in the vignette to assess their willingness to interact with the individual.

Participants then completed items from the Attributions Questionnaire, followed by the adapted Bogardus Social Distance Scale. The order of presentation was counterbalanced.

Following that, participants completed an adapted version of the Level of Contact Report.

The final measure completed was the Marlowe-Crowne Social Desirability Scale, which has been shown to have a reliability score of .88.

Finally, participants were presented with the debriefing form.

CHAPTER III

RESULTS

Table 1 shows the mean scores and standard deviations for desired social distance for each of the experimental groups.

Table 1

Desired Social Distance

Group	*n*	*M*	*S.D.*
Control	99	3.33	1.22
Mental Illness	93	3.16	1.39
Anxiety	96	3.03	1.34
Bipolar Disorder	93	3.51	1.10
Schizophrenia	99	3.68	.93

Hypotheses and Analysis

Hypothesis 1

The first hypothesis predicted that individuals would desire greater amounts of social distance from an individual with any mental illness label than from a person without a label. An ANOVA was conducted to test this. Results showed that there was a significant difference in desired social distance, though the effect size of that difference was small $F(4, 475) = 4.51$, $p = .001$, $\eta^2 = .04$. However, a post-hoc analysis showed that, contrary to my hypothesis, this difference was not found between the control group and any other mental illness label group. The difference was found only between the Schizophrenia label group ($M = 3.68$, $SD = 0.93$, $n = 99$) and the "Mental Illness" label group ($M = 3.16$, $SD = 1.39$, $n = 93$), and between the schizophrenia label group and the Anxiety label group ($M = 3.03$, $SD = 1.34$, $n = 96$).

These mean scores indicated that people desired greater social distance from a person with Schizophrenia than from a person with a "Mental Illness" or Anxiety.

Hypothesis 2

The second hypothesis predicted that participants would desire more social distance from an individual labeled as having Bipolar Disorder than from one labeled as having Anxiety. An independent samples t-test showed that, as hypothesized, participants desired more social distance from an individual labeled as having Bipolar Disorder ($M = 3.51$, $SD = 1.10$, $n = 93$) than one labeled as having Anxiety $t(187) = -2.65$, $p = .009$.

Hypothesis 3

The third hypothesis predicted that participants would desire greater social distance from an individual labeled as having Schizophrenia than from one who was labeled as having Bipolar Disorder. An independent samples t-test indicated that, contrary to my hypothesis, there was not a significant difference between the amount of social distance desired from an individual labeled as having Bipolar Disorder and an individual labeled as having Schizophrenia $t(190) = -1.19$, $p = .234$.

Hypothesis 4

The fourth hypothesis predicted that participants who had more familiarity with mental illness would desire less social distance overall. It was hypothesized that participants who had more familiarity with mental illness would desire less social distance overall. The potential correlation between participants' familiarity with mental illness and desired social distance was tested using Pearson's *r*. Results

showed a weak correlation between the two variables, $r(478) = -.18$, $p <= .000$, Familiarity scores ranged from 1 to 12 ($M = 7.84$, $SD = 3.52$, $n = 480$). Social distance scores ranged from 1 to 6 ($M = 3.34$, $SD = 1.22$, $n = 480$). Thus, as familiarity increased, desire for social distance decreased.

Exploratory Analysis

Table 2

Regression Analysis for Predictor Variables of Desired Social Distance

Variable	β	*SE*	*t*	*p**
Perceived Dangerousness	.46	.018	3.91	.000
Fear	.08	.017	.78	.436
Familiarity	–.11	.014	–2.74	.006
Social Desirability	–.10	.008	–2.55	.011

*Significance at $p <.05$

Though there were no specific hypotheses about predictors for social distance, a Multiple Regression Analysis was conducted as an exploratory analysis to determine the influence of the covariates of fear, perceived dangerousness, familiarity with mental illness, and social desirability on desired social distance (See Table 2). Results showed that when considered all together, perceived dangerousness, fear, familiarity with social distance, and social desirability were all significant predictors for desired social distance $F(4,476) = 46.66$, $p = .000$. When looked at on an individual level, perceived dangerousness ($\beta = .46$, $p = .000$), familiarity with mental illness ($\beta = -.11$, $p = .006$), and social desirability ($\beta = -.10$, $p = .011$) were all significant predictors of desired social distance. Fear ($\beta = .08$, $p = .436$) was not a significant predictor for desired social distance. Beta scores indicate that, even though familiarity and social desirability are predictors for lower scores of desired social

distance, dangerousness is still a greater predictor for high levels of desired social distance.

CHAPTER IV

DISCUSSION

This study aimed to examine the influence that a mental illness label has on desired social distance. It was expected that participants would desire greater social distance from individuals with any label of mental illness than from a person who did not have a mental illness label. No significant difference was found when comparing the control group to any of the other groups. When considered as a stand-alone result, this suggests that labels may not have any effect on desired social distance. However, the ANOVA that showed that insignificant result also showed that people desired greater social distance from individuals labeled with Schizophrenia than from individuals labeled has having a general "Mental Illness" and individuals labeled as having Anxiety. The vignette that did not include a mental illness label simply disclosed information about the person, including their hobbies and current major in college. Given that the vignettes did not include the information about college, but rather the inclusion of the mental illness label and its short definition, the implication is not that labels do not matter, but rather that labels may matter more than traits when determining how much someone wants to interact with someone else.

Analyses also showed that participants desired greater social distance from an individual labeled as having Bipolar Disorder than from an individual labeled as having Anxiety. This suggests that there may be a greater stigma attached to Bipolar Disorder than to Anxiety. This could be due to the prevalence of Anxiety disorders in the country and that information about anxiety in general is more accessible and

easily understood than information about Bipolar Disorder. It is also possible that the stereotypes of and emotional reactions towards Bipolar Disorder are more negative than those of anxiety.

That same lack of information and possible negative reactions towards and stereotypes of Bipolar Disorder may explain why analyses showed that there was not a significant difference in desired social distance from an individual labeled as having Bipolar Disorder than from an individual labeled as having Schizophrenia. Neither of these disorders are very prevalent in society, which means that the general public is not going to have as much experience with, or access to information about, either disorder.

Familiarity was shown to be a significant predictor in desired social distance. More specifically, it was shown to have a negative relationship with desired social distance, which means that when people had higher levels of familiarity with mental illness, they desired less social distance. It stands to reason that the less people know about a given mental illness, the more they are going to avoid people who have whatever the mental illness may be.

What had a greater impact on desired social distance, however, was not familiarity. It was the perceived dangerousness of the person in the vignette. Prior the research has shown that perceived dangerousness and fear go hand-in-hand, but results of this study suggest that those factors may not be as related as previously thought. While fear and perceived dangerousness may be related, perceived dangerousness seems to prompt people to engage in more avoidant behaviors. These

avoidant behaviors can exacerbate public stigma, which can then lead to greater amounts of self-stigma, which can in turn lead to worsened symptoms of a person's mental illness (Markowitz et al, 2011).

Social desirability was also shown to be a significant predictor for desired social distance, but because of that, the extent to which people admit to desiring or engaging in these avoidant, or socially distant behaviors, may actually be underreported. That being said, perceived dangerousness was still shown to have a stronger relationship with desired social distance than anything else, which suggests that, regardless of what people say, they may still act in ways that perpetuate stigma.

Limitations

One limitation of this study was the way the vignettes were written. They did not include many details about the person described other than the label of their mental illness and a very short description of what that mental illness was. I made the choice to keep the vignettes as vague as possible in an attempt to control for the confounding variables that would have been in place had there been a description of active symptoms of the given mental illness. This was done because this study was intended to fill in a gap in the research about the influence of labels on their own, as prior research on mental illness stigma frequently uses descriptions of symptoms of a given mental illness. In addition to filling this gape in the research, the lack of details about symptoms has an element of realism. In the real world, when one person is introduced to another, they likely are only going to get minimal information, such as a

name, major in school, and possibly the name of a mental illness diagnosis, on which to base their initial reaction.

Another limitation of the study is the length of the survey. The majority of the questionnaires were over ten items long and it is possible that not every participant read through every word.

Another limitation is the participants' level of honesty. While the social desirability measure at the end allowed for control of participants answering in socially desirable ways, it does not necessarily control for participant honesty. That is not to say that participants purposely answered dishonestly, but rather that they may have believed they were answering honestly, but may not have been being entirely truthful with themselves.

Future Directions

The results of this study suggest that, while there is a significant impact of labels on desired social distance, labels on their own may not have the strongest influence. It would be beneficial to look into what factors go into a person's judgement of mental illness as a whole, possibly through an interview-based study that explores the thoughts and feelings about, as well as the stereotypes associated with mental illness.

It would also be beneficial for research to examine what elicits a fear response versus what elicits a perception of dangerousness. Often these two factors are thought to go hand-in-hand, but the extent of their interaction is not yet clear. A deeper

understanding of their relationship could help to better explain each one's role in stigma.

Finally, more research should be done on the relationship between education, familiarity and stigma. Results of this study indicated that familiarity did have a significant impact on desired social distance, but it did not look specifically at how education influenced desired social distance.

This study was also conducted prior to government shut-downs due to COVID-19. Since the shelter-in-place orders have went into effect, there has been a growth in how much mental health is talked about in media, both in news media and in social media. It would be interesting to see how results of this study changed were it to be conducted again post-COVID-19 shut downs. The greater emphasis on, and more widespread mention of, mental health will likely lead to more knowledge about how mental health works, and in turn could possibly lead to lower levels of stigma.

CHAPTER V

CONCLUSIONS

While this study did not find significance between every mental illness label tested, and while the effect size of the significance that was found was small, stigma does still exist. Stigma has very real implications for those who are stigmatized. It can affect their employment, their ability to find housing, and even their simple, social interactions. Stigma can be troubling and even lead to worsening symptoms for some people, which can then in turn lead to even more stigmatization. Stigma needs to be further explored. We need to understand what factors contribute it, and the extent to which those factors have an effect.

Research into stigma was important before the COVID-19 shut downs, but may be even more important now during the shut downs and after they are lifted. Stigma has a large impact on how people interact with one another and with the changes that are currently happening in society, it is important to understand how that may have changed. In addition to learning how stigma works, further research into it can help us to understand how to combat the negative effects of stigma and create a society that is more accepting of those who are different.

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APPENDICES

APPENDIX A

INFORMED CONSENT

1. **Summary:** This research study will examine factors that are related to the social distance desired from individuals who are labeled as having a mental illness. If you agree to participate, you will be asked to answer survey questions that ask about your willingness to interact with and perceptions of individuals with a mental illness.

2. **Your right to withdraw/discontinue:** You are free to discontinue your participation at any time without penalty. You may also skip any survey questions that make you feel uncomfortable. Even if you withdraw from the study, you will receive any entitlements that have been promised to you in exchange for your participation, such as compensation.

3. **Benefits:** Participation in this research study does not guarantee any benefits to you. However, possible benefits include the fact that you may learn something about how research studies are conducted and you may learn something about this area of research (i.e., factors that contribute to stigma of mental illness).

4. **Additional information:** You will be given additional information about the study after your participation is complete.

5. **Time commitment:** If you agree to participate in the study, it may take up to 20 minutes to complete the survey.

6. **Guarantee of Confidentiality:** All data from this study will be kept from inappropriate disclosure and will be accessible only to the researchers and their faculty advisor. Data collected online will be stored on a password-protected website and de-identified for analyses. The researchers are not interested in anyone's individual responses, only the average responses of everyone in the study.

7. **Risks**: The present research is designed to reduce the possibility of any negative experiences as a result of participation. Risks to participants are kept to a minimum. However, if your participation in this study causes you any concerns, anxiety, or distress, please contact the National Suicide Prevention Lifeline at 800-273-8255 where you will be directed to a crisis help line near your location.

8. **Researcher Contact Information:** This research study is being conducted by Kyla McClure. The faculty supervisor is Dr. AnaMarie Guichard, Assistant Professor, Department of Psychology and Child Development, California State University, Stanislaus. If you have questions or concerns about your participation

in this study, you may contact the researcher through Dr. Guichard at (209) 667-3382.

9. **Results of the Study:** You may obtain information about the outcome of the study at the end of the academic year by contacting Dr. Guichard by phone at (209) 667-3382 or by email at aguichard@csustan.edu.

10. **Psychology Institutional Review Board Contact Information:** If you have any questions about your rights as a research participant, you may contact the Chair of the Psychology Institutional Review Board of California State University Stanislaus, Dr. Jessica Lambert at PsychologyIRB@csustan.edu or (209) 667-3934.

11. **Personal Copy of Consent Form**: You may print a blank, unsigned copy of this consent form at the beginning of the study.

12. **Verification of Adult Age:** By clicking "I Agree" below you attest that you are 18 years old or older.

13. **Verification of Informed Consent:** By clicking "I Agree" below you are indicating that you have freely consented to participate in this research study.

- ○ I Agree
- ○ I Do Not Agree

**Please note: For applications requesting the recruitment of minors, please include procedures for collecting both informed consent of the minor participant's parent or guardian AND informed assent of the minor participant.*

APPENDIX B

DEMOGRAPHIC QUESTIONNAIRE

The following questions inquire about your demographic information. Providing this information will allow more insight about the participants of this study. Please answer the following questions as accurately as possible.

1. What is your gender?
    A. Male
    B. Female
    C. Transgender
    D. Non-binary
    E. Other

2. What is your age (in years)?
    _____

3. What is your ethnicity?
    a. White
    b. Black
    c. Latino/Latina
    d. Native American/Pacific Islander
    e. Asian
    f. Other

APPENDIX C

VIGNETTES

Control Vignette

Hi, my name is Taylor and I am currently a junior in college. About a year ago, I changed my major from sociology to communications. I live at home with my parents, my younger brother and sister, and our dog. I'm still not sure what I want to do for my career. One of my favorite hobbies is binge-watching shows on Netflix.

Mental Illness Vignette

Hi, my name is Taylor and I am currently a junior in college. About a year ago, I was diagnosed with a mental illness. I live at home with my parents, my younger brother and sister, and our dog. I'm still not sure what I want to do for my career. One of my favorite hobbies is binge-watching shows on Netflix.

Anxiety Vignette

Hi, my name is Taylor and I am currently a junior in college. About a year ago, I was diagnosed with Generalized Anxiety Disorder, which means I sometimes get overwhelmed with worry. I live at home with my parents, my younger brother and sister, and our dog. I'm still not sure what I want to do for my career. One of my favorite hobbies is binge-watching shows on Netflix.

Bipolar Vignette

Hi, my name is Taylor and I am currently a junior in college. About a year ago, I was diagnosed with Bipolar Disorder, which means I sometimes have uncontrollable mood swings and energy levels. I live at home with my parents, my younger brother

and sister, and our dog. I'm still not sure what I want to do for my career. One of my favorite hobbies is binge-watching shows on Netflix.

Schizophrenia Vignette

Hi, my name is Taylor and I am currently a junior in college. About a year ago, I was diagnosed with Schizophrenia, which means I sometimes hear and see things that others don't. I live at home with my parents, my younger brother and sister, and our dog. I'm still not sure what I want to do for my career. One of my favorite hobbies is binge-watching shows on Netflix.

APPENDIX D

ADAPTED BOGARDUS SOCIAL DISTANCE QUESTIONNAIRE

Please respond to the following questions about your impressions of Taylor. You will be given the opportunity to answer the questions on a six-point scale, with 1 being "I certainly would" and 6 being "I certainly would not." Please answer as honestly as possible.

Would you speak to Taylor if you passed each other on the street?
1 2 3 4 5 6
Would you have lunch with Taylor?
1 2 3 4 5 6
Would you do school work with Taylor?
1 2 3 4 5 6
Would you go to a party at Taylor's house?
1 2 3 4 5 6
Would you invite Taylor to your house?
1 2 3 4 5 6
Would you take a job working with Taylor?
1 2 3 4 5 6
Would you move in next door to Taylor?
1 2 3 4 5 6
Would you be Taylor's friend?
1 2 3 4 5 6
Would you rent a room to Taylor?
1 2 3 4 5 6
Would you recommend Taylor for a job?
1 2 3 4 5 6
Would you support a relationship between Taylor and your sibling?
1 2 3 4 5 6
Would you trust Taylor to look after your child?
1 2 3 4 5 6

APPENDIX E

ATTRIBUTIONS QUESTIONNAIRE

Answer each of the following questions about Taylor. Circle the number of the best answer to each question.

1. I would feel aggravated by Taylor.
   1 2 3 4 5 6 7 8 9
   not at all very much

2. I would feel unsafe around Taylor.
   1 2 3 4 5 6 7 8 9
   no, not at all yes, very much

3. Taylor would terrify me.
   1 2 3 4 5 6 7 8 9
   not at all very much

4. How angry would you feel at Taylor?
   1 2 3 4 5 6 7 8 9
   not at all very much

5. If I were in charge of Taylor's treatment, I would require Taylor to take medication.
   1 2 3 4 5 6 7 8 9
   not at all very much

6. I think Taylor poses a risk to neighbors unless hospitalized.
   1 2 3 4 5 6 7 8 9
   none at all very much

7. If I were an employer, I would interview Taylor for a job.
   1 2 3 4 5 6 7 8 9
   not likely very likely

8. I would be willing to talk to Taylor about problems.
   1 2 3 4 5 6 7 8 9
   not at all very much

9. I would feel pity for Taylor.

1 2 3 4 5 6 7 8 9

none at all very much

10. I would think that it was Taylor's own fault that they are in the present condition.

1 2 3 4 5 6 7 8 9

no, not at all yes, absolutely so

11. How controllable, do you think, is the cause of Taylor's present condition?

1 2 3 4 5 6 7 8 9

not at all completely

12. How irritated would you feel by Taylor?

1 2 3 4 5 6 7 8 9

not at all very much

13. How dangerous would you feel Taylor is?

1 2 3 4 5 6 7 8 9

not at all very much

14. How much do you agree that Taylor should be forced into treatment by a doctor?

1 2 3 4 5 6 7 8 9

not at all very much

15. I think it would be best for the community if Taylor were put away in a psychiatric hospital.

1 2 3 4 5 6 7 8 9

not at all very much

16. I would share a car pool with Taylor every day.

1 2 3 4 5 6 7 8 9

not likely very likely

17. How much do you think an asylum, where Taylor can be kept away from their neighbors, is the best place for them?

1 2 3 4 5 6 7 8 9

not at all very much

18. I would feel threatened by Taylor.

1 2 3 4 5 6 7 8 9

not at all very much

19. How scared of Taylor would you feel?
1 2 3 4 5 6 7 8 9
not at all very much

20. How likely is it that you would help Taylor?
1 2 3 4 5 6 7 8 9
not at all very much

21. How certain would you feel that you would help Taylor?
1 2 3 4 5 6 7 8 9
not at all certain absolutely certain

22. How much sympathy would you feel for Taylor?
1 2 3 4 5 6 7 8 9
not at all very much

23. How responsible, do you think, Taylor is for their present condition?
1 2 3 4 5 6 7 8 9
not at all very much

24. How frightened of Taylor would you feel?
1 2 3 4 5 6 7 8 9
not at all very much

25. If I were in charge of Taylor's treatment, I would force them to live in a group home.
1 2 3 4 5 6 7 8 9
not at all very much

26. If I were a landlord, I probably would rent an apartment to Taylor.
1 2 3 4 5 6 7 8 9
not likely very likely

27. How much concern would you feel for Taylor?
1 2 3 4 5 6 7 8 9
not at all very much

APPENDIX F

LEVEL OF CONTACT REPORT

Please read each of the following statements carefully. After you have read all the statements below, place a check by the statements that best depict your exposure to persons with a mental illness.

___ I have watched a movie or television show in which a character depicted a person with mental illness.

___ My job involves providing services/treatment for persons with a mental illness.

___ I have observed, in passing, a person I believe may have had a mental illness.

___ I have observed persons with a mental illness on a frequent basis.

___ I have a mental illness.

___ I have worked with a person who had a mental illness at my place of employment.

___ I have never observed a person that I was aware had a mental illness.

___ My job includes providing services to persons with a mental illness.

___ A friend of the family has a mental illness.

___ I have a relative who has a mental illness.

___ I have watched a documentary on the television about mental illness.

___ I live with a person who has a mental illness.

APPENDIX G

MARLOWE-CROWNE SOCIAL DESIRABILITY SCALE

Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide whether the statement is true or false as it pertains to you.

1. Before voting, I thoroughly investigate the qualifications of all the candidates. True False
2. I never hesitate to go out of my way to help someone in trouble True False
3. It is sometimes hard for me to go on with my work if I am not encouraged True False
4. I have never intensely disliked anyone. True False
5. On occasion I have doubts about my ability to succeed in life. True False
6. I sometimes feel resentful when I don't get my own way. True False
7. I am always careful about my manner of dress. True False
8. My table manners at home are as good as when I eat out in a restaurant. True False
9. If I could get into a movie without paying and be sure I was not seen, I would probably do it. True False
10. On few occasions, I have given up doing something because I thought too little of my ability. True False

11. I like to gossip at times.	True	False
12. There have been times when I felt like rebelling against people in authority even though I knew they were right.	True	False
13. No matter who I'm talking to, I'm always a good listener.	True	False
14. I can remember "playing sick" to get out of something.	True	False
15. There have been occasions when I took advantage of someone.	True	False
16. I'm always willing to admit it when I make a mistake.	True	False
17. I always try to practice what I preach.	True	False
18. I don't find it particularly difficult to get along with loud-mouthed, obnoxious people.	True	False
19. I sometimes try to get even, rather than forgive and forget.	True	False
20. When I don't know something I don't at all mind admitting it.	True	False
21. I am always courteous, even to people who are disagreeable.	True	False
22. At times I have really insisted on having things my own way.	True	False
23. There have been occasions when I felt like smashing	True	False

things.

24. I would never think of letting someone else be punished for my own wrongdoings.	True	False
25. I never resent being asked to return a favor.	True	False
26. I have never been irked when people expressed ideas very different from my own.	True	False
27. I never make a long trip without checking the safety of my car.	True	False
28. There have been times when I was quite jealous of the good fortune of others.	True	False
29. I have almost never felt the urge to tell someone off.	True	False
30. I am sometimes irritated by people who ask favors of me.	True	False
31. I have never felt that I was punished without cause.	True	False
32. I sometimes think when people have a misfortune they only got what they deserved.	True	False
33. I have never deliberately said something that hurt someone's feelings.	True	False

APPENDIX H

DEBREIFING FORM

Thank you for participating in this study! I am interested in understanding more about the concept of social distance. Social distance is defined as the amount of social interaction an individual is willing to interact with another individual. Social distance is often used to measure social bias against different groups, such as those of different ethnicities. I wanted to understand how the knowledge of a person's mental illness might affect others' desire to associate with them.

The questionnaires that you answered after reading the passage were meant to measure the amount of social distance you desired from the hypothetical person described in the passage you read, your emotional perceptions of them, your familiarity with mental illness in general, and your tendency toward social desirability. However, not all participants read the same passage. There were four possible passages that you could have been presented with. One passage described an individual who did not have a mental illness, one described an individual with Generalized Anxiety Disorder, one described an individual with Bipolar Disorder, and one described an individual with Schizophrenia. Other than the sentences that described the mental illness of the person, the passages were the same.

Prior research suggests that stigma towards those with a mental illness exists, which may be demonstrated through desired social distance. This desire for social distance may be mediated by an individual's perception of how dangerous the person is, as well as their level of fear towards them. Studies have found that greater social

distance was preferred from an individual described as depressed or schizophrenic than from someone who was not described as mentally ill. In many of these studies, individuals who had more negative emotional reactions tended to desire more social distance. I expect to find something similar when it comes to this study. I predict that participants who read about the individual with Bipolar Disorder will desire more social distance than the participants who read about the individual with Generalized Anxiety Disorder. I predict that participants who read about the individual with Schizophrenia will desire greater social distance than participants who read about any of the disorders. I will also assess the extent to which the participants' familiarity with mental illness, and fear and perceived dangerousness of the individual influences their desired social distance.

All the information we collected in this study will be kept safe from inappropriate disclosure, and there will be no way of identifying your responses in the data archive. I am not interested in anyone's individual responses; rather, I want to look at the general patterns that emerge when all of the participants' responses are put together. We ask that you do not discuss the nature of the study with others who may later participate in it, as this could affect the validity of our research conclusions.