POLITICAL ORIENTATION AS ASSOCIATED WITH STIGMATIZING AND
AFFIRMING ATTITUDES TOWARD MENTAL ILLNESS

BY

KARINA J. POWELL

COLLEGE OF PSYCHOLOGY

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Approved _________________________
Adviser

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ABSTRACT

Stigma toward people with mental illness can have deleterious effects; employers avoid hiring them, landlords avoid renting to them, and negative attitudes are often a barrier to receiving quality health care. Literature on political ideology indicates that people tend to have fairly stable attitudes over time that are consistent with their political orientation. It is also the case that political ideology is an underlying factor of attitudes toward personal responsibility and hierarchical societal structure. Political ideology, as an underlying framework for attributing controllability through which many individuals view the world, is a demographic variable that needs to be further explored to more completely integrate variances into anti-stigma approaches. Pre-intervention data from a larger study assessing the effects of newspaper articles on attitudes about mental illness were utilized to examine the influence of political orientation on stigmatizing and affirming attitudes toward people with mental illness. Pearson product moment correlations between demographics, political orientation variables, stigmatizing attitudes, and affirming attitudes were conducted. Regression analyses were conducted to determine if political orientation or the interaction between political orientation and demographics are significantly related to stigmatizing attitudes. Results showed that political affiliation emerged as significant associated with pity, danger, blame, and anger when moderated by other demographics suggesting that endorsement of affiliation with a particular political party alone is not sufficient to emerge as related to stigmatizing attitudes, but rather varies at levels of other demographic variables.
Advocates and researchers agree that public attitudes toward people with mental illness are generally negative, resulting in deleterious effects on the individual. Employers avoid hiring people with mental illness, landlords avoid renting to them, and negative attitudes are often a barrier to receiving quality health care (Sartorius, Stuart, & Arboleda-Florez, 2012). For those who internalize these negative public perceptions, there is a harmful effect on the individual’s sense of self-worth and self-esteem (Ritsher & Phelan, 2004; Corrigan & Watson, 2002). While society’s understanding of mental illness has expanded over the past several decades (Markowitz, 1998), negative perceptions are still promulgated by the media, increasing perceptions of violence and portraying people with mental illness as unpredictable, dangerous, or child-like (Sieff, 2003; Thornicroft, 2006; Wahl, 1995). These beliefs are widely endorsed around the world in Europe (Crisp, Gelder, Goddard, & Meltzer, 2005; Gaebel, Baumann, & Phil, 2003; Hamre, Dahl, & Malt, 1994; Mehta, Kassam, Lesse, Butler, & Thornicroft, 2009; Shomerus, Matschinger, Kenzin, Breier, & Angermeyer, 2006), Australia (Jorm & Wright, 2005), Asia (Lauber & Rossler, 2007), Africa (Adewuya & Makanjuola, 2005), and South America (de Toledo Piza Peluso, & Blay, 2004).

Understanding individual factors that impact attitudes about people with mental illness is important in both research and practice, particularly in the development of effective attitude change strategies. Research has shown that demographic variables are related to attitudes toward people with mental illness, including gender (Leong & Zachar,
1999; Mann & Himelein 2004), age (Ojanen, 1992), race (Halter, 2004; Stickney, Yanosky, Black, & Stickney, 2012), religious affiliation (Halter, 2004), and educational level (Ojanen, 1992; Stickney, Yanosky, Black, & Stickney, 2012). Comprehensive approaches to combating stigma need to be aware of individual differences related to stigmatizing attitudes and take these into consideration when creating interventions and targeting specific populations. Political ideology, as an underlying framework for attributing controllability through which many individuals view the world, is a demographic variable that needs to be further explored to more completely integrate variances into anti-stigma approaches.

Chapter 1 is structured to discuss the conceptual model of stigma, the attribution theory, and political ideology and investigates the relationship between these constructs. The objective of this study is to explore the relationship between political ideology on attitudes toward mental illness. Our goal is to investigate correlations between these constructs and determine if political orientation is related to factors of stigma.

1.1 Attitudes toward People with Mental Illness

The term “stigma” was adopted by Goffman in 1963 who defined it as “an attribute that is deeply discrediting” (pp. 3), specifically a mark meant to publicly and prominently represent immoral status. Stigmas, therefore, are typically the marks that lead to discrediting the individual and aversive or damaging behavioral responses when observed by a majority member. Goffman noted that some stigmas are readily apparent and based on physical or overt signs such as skin color (ethnicity cue), body shape (gender cue), or body size (obesity cue). Other stigmas are based on hidden cues, not
observable *per se*. For example, people cannot typically determine who falls into such stigmatized groups as gay men, members of religious minorities, and people with mental illness. Hidden stigma is indicated by label or association rather than overt physical cues (Link, Cullen, Frank, & Wozniak, 1987; Penn & Martin, 1998). It can be ascertained based on self-disclosure (i.e., “I have a mental illness.”) or association (e.g., observation of someone entering a psychiatric clinic might lead to the assumption that the person is mentally ill).

Research indicates that the general public identifies mental illness from four types of cues: social-skills deficits, physical appearance, psychiatric symptoms, and labels (Corrigan, 2004). Some of the symptoms of severe mental illness may include social-skills deficits, resulting in stigmatizing responses from others. Many individuals associate poor physical hygiene and appearance with severe mental illness, identifying an “unkempt” person as having a mental illness, and subsequently avoiding him or her with the stereotypes of dangerousness and unpredictability foremost in their minds. Some psychiatric symptoms that are present with severe mental illnesses, such as inappropriate affect and positive symptoms, can act as a cue that will trigger a stigmatizing reaction.

Stereotypes are described as knowledge structures that are learned by most members of a social group (Cox, Abramson, Devine, & Hollon, 2012; Hilton & von Hippel, 1996; Judd & Park, 1993; Krueger, 1996; McGarty, Yzerbyt, & Spears, 2002; Mullen, Rozell, & Johnson, 1996). They are often identified as an efficient way to organize information and conserve mental resources and time, since individuals can quickly create impressions and expectations of those members of the stereotyped group (Hamilton & Sherman, 1994). Stereotypes can be positive or negative representations of
certain groups of people. However, the overt expression of any stereotypes (regardless of whether they are positive or negative) can have an adverse impact on individuals of the stereotyped social group, particularly when coupled with an affective response eliciting a prejudiced attitude (Ottati, Bodenhausen, & Newman, 2005).

Prejudice, as a cognitive and affective response, involves a typically negative evaluative component, often leading to a behavioral reaction (Corrigan & Wassel, 2008). Known stereotypes in the presence of prejudice by a majority member often results in discrimination, or the loss of opportunity or fair treatment. However, just because people may have knowledge of a stereotype does not imply that they agree with or act on it (Devine, 1989; Jussim, Nelson, Manis, & Soffin, 1995). For example, people can endorse stereotypes about different racial groups but do not agree that the stereotypes are valid generalizations. People who are prejudiced though, likely endorse these negative stereotypes and produce negative emotional and behavioral reactions, resulting in discrimination (Devine, 1989, 1995; Hilton & von Hippel, 1996; Krueger, 1996).

Discriminatory behavior frequently displays itself as negative action against the stigmatized group. Discrimination for people with mental illness includes coercion, withholding help, avoidance, and segregation (Corrigan, Markowitz, Watson, Rowan & Kubiak, 2003). These discriminatory behaviors are detrimental to all areas of psychosocial functioning, limit opportunities and reduce the quality of life for those diagnosed with mental illness. Employers, for example, are less likely to hire individuals labeled as mentally ill (Bordieri & Drehmer, 1986; Farina & Felner, 1973; Link, 1987) and landlords less likely to rent/lease housing to those labeled as mentally ill (Alisky, 1990; Page, 1977, 1983).
Examining stigmatizing attitudes may not be enough, however. Absence of negative attitudes does not necessarily advance social inclusion for people with mental illness (Corrigan, Powell, & Michaels, In Review). Social inclusion promotes access to necessary resources, including economic, interpersonal, spiritual, and political options that help individuals obtain personal goals (Leff & Warner, 2006; Lloyd, Waghorn, & Williams, 2008). Influencing ideas of social inclusion and underlying the construct of affirming attitudes are concepts of recovery, empowerment, and self-determination. Recovery is the ability of individuals with mental illness to live meaningful, goal-oriented lives beyond the constraints of their psychiatric symptoms (Corrigan, Giffort, Rashid, Leary, & Okeke, 1999; Harding, Brooks, Ashikaga, Strauss, & Breier, 1992; Harrison et al., 2001). Empowerment transpires from recovery and is the idea that individuals must have control over treatment and personal life goals (Rogers, Ralph, & Salzer, 2010). In helping individuals foster empowerment, self-determination emerges as the notion that people with mental illness have personal goals that are achievable and should be pursued. In assessing each of these constructs from the public’s perspective, three measures were utilized in this study: the Recovery Scale, Self-Determination Scale, and Empowerment Scale. All of these scales have been shown to be valid and reliable (Corrigan, Powell, & Michaels, In Review; Corrigan, Powell, & Michaels, 2013).

Stigma is one of the most challenging barriers to community inclusion for people with mental illness (Link & Phelan, 2001). The depth and breadth of the processes that sustain stigma make it particularly challenging for the development of successful interventions across groups in which discrimination toward people with mental illness is prominent. Much research has focused on reducing stigmatizing attitudes in the general
Understanding theoretical models of stigma, such as Weiner’s (1995) attribution theory model, will likely help to provide further guidance and insight into how different stigmatizing attitudes are intertwined.

### 1.2 Attribution Theory

Understanding how attribution of controllability and responsibility influences stigmatizing attitudes toward people with mental illness is important in conceptualizing stigma research. In exploring the process of beliefs and attitudes translating into a behavioral response, Weiner (1995) identified a model of attribution that is mediated by a cognitive-emotional process (Figure 1). In accordance with this model, following identification of a cue that identifies the individual as different or undesirable, people make inferences about the cause and controllability of the attribute (e.g., mental illness). The judgment of whether one’s mental illness is controllable or not leads to conclusions regarding responsibility. Controllability is determined by characteristics of the circumstances or cause of the mental illness, whereas responsibility is related to a direct judgment of the individual. For example, if an individual’s mental illness is attributed to forces under the person’s control (e.g., bad character), he/she will be deemed responsible. However, if it is attributed to circumstances beyond the individual’s control (e.g., a car accident, congenital factors), he/she will not be identified as responsible. Research suggests that illness course or stability has an impact on assignment of responsibility. Conditions, such as mental illness, that are identified as controllable and reversible tend to be viewed more negatively and result in greater social rejection (Jones et al., 1984). Those viewed as
uncontrollable and irreversible, such as Alzheimer’s disease or paraplegia, tend to elicit fewer negative attitudes.

Assignment of responsibility leads to affective responses, such as pity or anger; belief that one is responsible for his/her mental illness leads to anger, while a lack of assignment of responsibility leads to pity (Weiner, 1995). The behavioral response is linked to the affective component elicited by assignment of responsibility; anger leads to punishing/neglectful behavior, whereas pity leads to helping behavior.

![Attribution Model](Based on Weiner, 1995)

Corrigan (2000) expanded upon the model postulated by Weiner (1995), to include an attitude often associated with people with mental illness; dangerousness (Figure 2; Cohen & Struening, 1962; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999; Pescosolido, Monahan, Link, Stueve, & Kikuzawa, 1999). In this model, identifying the behavior of a person with mental illness as dangerous can lead to a fear response (Corrigan, 2000), which, in turn leads to apprehension and avoidance. Research supports this model; perceptions of dangerousness lead to fear and avoidance (Madianos, Madianou, Vlachonikolis, & Stefanis, 1987, Levey & Howells, 1995). One study in particular attributed two political assassination attempts to a person with schizophrenia which led to greater perceptions of dangerousness and fear, and in turn, greater social distance between the general public and
people with mental illness (Angermeyer & Matschinger, 1996). Those who do not attribute dangerousness to people with mental illness tend to exhibit less fear and less desire for social distance. Avoidance then leads to discriminatory behaviors, such as the desire to force people into treatment, segregate them from the community, and failing to employ or rent housing to people with mental illness.

**Figure 2.** Attributions of Dangerousness, Fear, and Avoidance Model (Based on Corrigan, 2000)

The Attribution Questionnaire-27 (AQ-27; Corrigan et al., 2002; Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003) was developed with this expanded attribution model as the underlying structure and modeled after Reisenzein (1986). This scale was created to address nine stereotypes about people with mental illness; blame, anger, pity, help, dangerousness, fear, avoidance, segregation, and coercion. These factors reflect the dimension that arise from the two path models discussed previously. From path one, assignment of blame leads to anger or pity which influence helping behavior. Endorsement of anger leads to punishing or neglectful behavior, while endorsement of pity leads to helping behavior. While pity may lead to helping behavior, it can also be construed as a negative emotion, identifying the subject of pity as inferior, implying a lack of respect and equality. From path two, perception of dangerousness incites fear and leads to
avoidance and the desire to coerce people into treatment and segregate them from the community. The AQ-27 presents a brief vignette about Harry, a man with schizophrenia, and asks participants to respond on a 9-point Likert scale. For the purposes of this study, a shortened 9-item version that loads on the same 9-factor stigma model was employed. Research has supported the AQ-9 as being reliable and valid (Corrigan, Watson, & Miller, 2006).

Further exploration between attribution theory and individual factors that influence attitudes can foster enhancements in the development of anti-stigma interventions. Understanding differences in attitudes by demographics, including political ideology, may help to target efforts and produce longer lasting effects. Attribution theory, as discussed previously, may aid in our general understanding of the connection between political ideology and behavior.

1.3 Political Orientation

Political ideology has been proposed to impact attitudes about people with mental illness, specifically in the context of controllability and the path represented by attribution theory (Watson, 2001). Literature on political ideology indicates that people tend to have fairly stable attitudes over time that are consistent with their political orientation (Sears, 1993) and that one’s orientation greatly impacts his/her attitudes about the world (Crandall & Biernat, 1990). Political ideology is an underlying factor of attitudes toward personal responsibility and hierarchical societal structure (Crandall, 2000). Identification with a particular ideology relate to beliefs regarding the endorsement or dismissal of a social hierarchical structure and attribution of personal responsibility for various aspects of one’s
life. For example, tending toward believing that one is responsible for his or her condition can lead to discrimination as it is identified that he or she is not living up to societal expectation and is personally responsible for his or her condition.

The two most widely identified poles of the political ideological orientation spectrum in the U.S. are conservatism and liberalism. Underlying conservative ideals are attitudes toward individualism, authoritarianism, traditional beliefs with regard to authority and belief in the Protestant work ethic (Kerlinger, 1984). Liberalism endorses attitudes related to humanitarian attitudes, tolerance of varying beliefs, and government action to help individuals in need. Research indicates that conservatism is related to attributions of personal responsibility (Skitka & Tetlock, 1992; Zucker & Weiner, 1993), and rejection and punishment behaviors toward individuals who do not meet social norms (Crandall, 2000; Skitka & Tetlock, 1993). Broadly applied, the core of the conservative perspective is the belief in a just world in which people are responsible for their situation and inevitably get what they deserve (Crandall & Biernat, 1990). Endorsement of conservative political ideology has been shown to be related to negative attitudes toward a variety of stigmatized groups, including African Americans (Katz & Haas, 1988), homosexuals (Irvine, 2005), and obese people (Crandall & Biernat, 1990).

In examining the relationship between ideology and attributions, Skitka and Tetlock (1992) studied political ideology and its relation to financial allocation decisions regarding government assistant programs for different groups. They found that individuals who identified as conservative were more likely to attribute personal responsibility to the individual, had more negative affective responses, and had higher ratings of disgust and lower ratings of deservedness. Those who identified as liberal endorsed more sympathy and
deservedness and lower ratings of disgust for all groups identified. Conservatism has been found to positively correlate with blame, anger, and attributes of personal responsibility and controllability and negatively correlate with pity, help, and attributes of external social causes (Zucker & Weiner, 1993). Watson (2001) found that individuals who identified as liberal were less likely to attribute a problem to bad character and that political ideology was a strong predictor of support for government assistance programs, with more conservative individuals endorsing less support for people with mental illness. Watson (2001) found support for an expanded attribution model in which political ideology influences the identification of controllability of cause and attribution of responsibility (Figure 3).

![Figure 3. Modified Attribution Theory (Based on Watson, 2001)](image)

While elaborate measures of political ideology have been developed, research has shown that a single item is highly correlated with these more lengthy measures (Farwell & Weiner, 2000); asking participants where they would place themselves on a 7-point Likert scale from conservative to liberal. For this study, we also examined participant’s political party affiliation by asking participants with which party they identify most (e.g., Democratic, Republican, Independent, Other). These two variables (i.e., political ideology and political affiliation) will be referred to collectively as political orientation.
Exploring correlations between political ideology and proxies of stigma can help in identifying the relationship between this underlying orientation and components of stigmatizing attitudes laid out in attribution theory. Additionally, understanding the correlational relationship between political ideology and affirming attitudes can inform future research on social inclusion. To accomplish this objective, correlations between political ideology, political affiliation, measures of affirming attitudes, and the nine factors that emerge from the AQ-9 will be examined. Measures of political ideology and political affiliation are hypothesized to be correlated. It is also hypothesized that liberalism will be positively correlated with pity, help, and the measures of affirming attitudes while conservatism will be positively correlated with blame, anger, dangerousness, fear, avoidance, coercion, and segregation. Further, determining the relationship between political orientation and stigmatizing and affirming attitudes can aid in better understanding factors that influence these attitudes and the development of stigma-reduction interventions aimed at specific populations. It is hypothesized that political orientation will emerge as significantly related to stigmatizing attitudes. Additionally, it is hypothesized that demographic variables will emerge as moderators of the relationship between political orientation and stigmatizing and affirming attitudes. The relationship between political orientation and moderating variables with regard to stigmatizing and affirming attitudes will be explored through multiple regression analyses.
CHAPTER 2

METHODS

The Institutional Review Board of Illinois Institute of Technology examined and approved all study methods and materials prior to data collection. Participants were recruited through an advertisement (Appendix A) posted on the Chicago, Illinois Domestic Gigs section of Craigslist ([www.craigslist.org/chicago/volunteers](http://www.craigslist.org/chicago/volunteers)). The study was accessed via secured hyperlink on Qualtrics ([www.qualtrics.com](http://www.qualtrics.com)), a more robust, intuitive data collection alternative to SurveyMonkey ([www.surveymonkey.com](http://www.surveymonkey.com)). Participants reviewed the study informed consent (Appendix B) and provided digital consent by indicating their agreement via electronic signature. To meet the inclusion criteria of 18 years or older, participants were asked to enter their year of birth; individuals who did not meet this criteria were directed to a notice that they were not eligible for participation in the study. Participants were then asked to complete a demographics questionnaire including gender, age, ethnicity, marital status, and political affiliation (Appendix C).

Following the consent, screening measure to ensure participants were over the age of 18 years, and completing the demographics questionnaire, participants completed pre-intervention questionnaires assessing stigmatizing attitudes, as well as affirming attitudes, which are beliefs related to concepts of social inclusion; recovery, empowerment, and self-determination. The order of the questionnaires was randomized, but individual items on each questionnaire remained static across participants. As part of the larger study from which this data was collected, participants were then randomized to one of three
interventions assessing the effects of newspaper articles on attitudes about mental illness. The effects of the intervention are to be published elsewhere as the data analysis here was limited to pre-intervention data for the sample. Participants were compensated with a $5 Amazon.com gift card for the successful completion of the study. Ten consenting participants chose to discontinue the study for undisclosed reasons.

2.1 Participants

Two hundred and three participants completed pre-intervention measures; the demographics are described in Table 1. Overall, the age of the sample ranged from 19 to 57, with the average age being 33 years (SD = 7.4). Participants included 32% women, 66% were married, and 84.2% had earned a bachelor’s degree or higher. Ethnic identity values should be interpreted with caution as 56.4% of respondents reported their ethnicity as Native American.
Table 1

_Demographic characteristics of sample (N = 203)_

<table>
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<tr>
<th>Variable</th>
<th>Mean (SD)/Frequency</th>
<th>%</th>
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<tbody>
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<td><strong>Sex</strong></td>
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<tr>
<td>Female</td>
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<td>32</td>
</tr>
<tr>
<td>Male</td>
<td>138</td>
<td>68</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>33.1 (7.4)</td>
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</tr>
<tr>
<td><strong>Ethnicity</strong></td>
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</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>13</td>
<td>6.4</td>
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<tr>
<td>African American</td>
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<td>6.9</td>
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<tr>
<td>European American</td>
<td>45</td>
<td>22.3</td>
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<tr>
<td>Native American</td>
<td>114</td>
<td>56.4</td>
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<tr>
<td>Multiple Ethnicities or</td>
<td>17</td>
<td>7.9</td>
</tr>
<tr>
<td>Other</td>
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<tr>
<td><strong>Marital Status</strong></td>
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<td>Single/Never Married</td>
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<td>23.2</td>
</tr>
<tr>
<td>Married</td>
<td>134</td>
<td>66</td>
</tr>
<tr>
<td>In Long Term Relationship</td>
<td>12</td>
<td>5.9</td>
</tr>
<tr>
<td>Separated/Divorced</td>
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<td>4.9</td>
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<td><strong>Educational Attainment</strong></td>
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<td><strong>Political Affiliation</strong></td>
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<td>Republican</td>
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<td>Independent</td>
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<td>15.2</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>1.4</td>
</tr>
</tbody>
</table>

2.2 Materials

**Political Ideation/Political Affiliation.** Included in the demographics measures were two questions inquiring about the participant’s political ideals. Political ideation was assessed by asking participants to rate themselves on a scale from 1 to 7 indicating liberal to conservative, respectively; the mean was 3.44. In terms of political affiliation,
84 participants identified as liberal and 19 identified as conservative. Research indicates that this single item, Likert-scale question is well correlated with more lengthy measures of assessing political ideation (Farwell & Weiner, 2000). In looking specifically at differences in attitude related to political party, political affiliation was measured by asking participants to indicate the party with which they identify (i.e., Democrat, Republican, Independent, Other). One hundred three respondents identified as Republican, 72 identified as Democrat, and 35 identified as Independent or other.

**Self-Determination Scale.** As part of the battery of questionnaires, participants completed the 14-item Self-Determination Scale (SDS; Appendix F). The SDS was created for this study to assess affirming attitudes, specifically community beliefs about the independent pursuit of important life goals by people with mental illness (i.e., “Harry should pursue a full-time job.”). On the SDS, participants read a vignette about a man with schizophrenia and provided responses to questions assessing their beliefs about his ability to pursue various life goals. Responses were provided using a nine-point scale (1 = strongly agree to 7 = strongly disagree). Total scores were computed as a sum of all 14-items, with lower scores indicating stronger agreement, representing beliefs that people with mental illnesses have the ability to pursue and achieve important life goals. Cronbach’s alpha for this scale was 0.80, which is an acceptable level of internal consistency.

**Recovery Scale.** Participants completed another measure of affirming attitudes, the Recovery Scale (RS; Appendix G), which is comprised of 13 Likert scale questions. The RS was modified from the original Recovery Assessment Scale (Corrigan, Giffort, Rashid, Leary, & Okeke, 1999), intended to assess the ability of people with mental
illness to live a satisfying life despite psychological difficulties related to their illness. The RS was revised to assess the public’s beliefs about a consumer’s potential for recovery and ability to live a satisfying life overcoming the constraints of one’s mental illness. An example item from this measure is, “People with mental illness are hopeful about their future.” Participants indicated their response to each item on a 7-point Likert scale (1 = strongly agree to 7 = strongly disagree). Overall RS scores were computed by summing the responses to the 13 aforementioned items with higher scores indicating greater disagreement. Cronbach’s alpha for this scale was 0.77.

Empowerment Scale. Participants completed the Empowerment Scale-3 (ES-3), a measure of affirming attitudes (Appendix H). Three items were selected from the original ES (Rogers, Chamberlin, Ellison, & Crean, 1997) that all loaded highly onto the self-esteem/self-efficacy factor that emerged from the measure (i.e., “I see people with mental illness as capable people.”). This measure was selected to assess the public’s perception of the relative worth of people with mental illness. Participants responded to questions assessing public perceptions about the personal agency of people with mental illness (1 = strongly agree to 7 = strongly disagree). An overall score was computed as the sum of responses to all three items, with higher scores representing greater disagreement. Cronbach’s alpha for this scale was 0.86, which is an acceptable level of internal consistency.

Attribution Questionnaire. Participants completed the nine item Attribution Questionnaire (AQ-9) at pre- and post-intervention. Individuals were presented with a brief vignette about a man with schizophrenia who lives alone and work full time. Participants then responded to questions in which they rated their reactions to the man
presented in the vignette using a Likert scale (1 = strongly agree to 7 = strongly disagree; i.e., “How dangerous would you feel Harry is?”). The AQ-9 is comprised of one item for each of the nine factors that emerged from path analyses of the concepts of responsibility and dangerousness (Corrigan et al., 2002). Factors representing responsibility include blame, pity, danger, and help and factors representing dangerousness include danger, fear, avoidance, coercion, and institutionalization. Path one theorizes that evaluation of responsibility for one’s mental illness elicits pity if blame is attributed to external factors or anger if blame is attributed to the individual. This, in turn, leads to helping behavior if pity if elicited or neglectful behavior if anger is elicited. Path two indicates that belief that an individual with mental illness is dangerous elicits fear and, in turn, leads to avoidance, resulting in negative behaviors such as coercion and segregation. In general, higher scores represent greater endorsement of stigmatizing attitudes toward the man with mental illness presented in the vignette: only the item representing “help” is reverse coded. Cronbach’s alpha for this scale was 0.62, which is an acceptable level of internal consistency for this measure.
CHAPTER 3

RESULTS

Participants who reported being ‘independent’ or ‘other’ for their political affiliation were excluded from the analysis due to the inability to identify a consistent political platform amongst these groups. Therefore, only participants who identified as aligning themselves with Democratic or Republican Parties were included in the analysis. This eliminated 32 cases resulting in a total sample size of 171.

Pearson product moment correlations between political ideation, political affiliation, and participant demographics are summarized in Table 2. Significant correlations were found between political affiliation and gender, race, and income. A negative correlation was found between gender and political affiliation indicating that more women identified as being affiliated with the Democratic Party. A positive correlation was indicated between income and political affiliation meaning that participants in a higher income bracket were more likely to report identifying with the Republican Party. The positive correlation between race and political affiliation indicates that more individuals who identified as White reported affiliation with the Republican Party than individuals who identified as non-White. There were no significant correlations between political ideation and demographic variables as exhibited in Table 2.
Table 2

Pearson product moment correlations between political ideation, political affiliation, and participant demographics (N=171).

<table>
<thead>
<tr>
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<th>Income</th>
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<td>-.403**</td>
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<td>-.198**</td>
<td>-.468**</td>
<td>.498**</td>
<td>.327**</td>
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</tr>
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</table>

Note. PI = Political Ideation; PA = Political Affiliation
* p < .05
** p < .01

Pearson product moment correlations between demographic variables and factors of the AQ-9 are summarized in Table 3. Participant age was not significantly correlated with any of the factors from the AQ-9. Attitudes of pity and dangerousness were endorsed by more women, while blame, segregation, anger, help, and avoidance were more highly endorsed by men. Non-White participants endorsed more attitudes of pity, danger, and fear, while White participants endorsed attitudes of blame, segregation, anger, and avoidance. Individuals with a Bachelor’s degree or higher reported more pity and fear, while participants with lower levels of education reported greater attitudes of
blame, anger, help, and coercion. Participants earning less than $150,000 per household per year reported higher levels of pity, danger, and fear, while those earning $150,000 or higher reported greater attitudes of segregation, anger, and coercion.

Table 4 summarizes correlations between political ideation, political affiliation, and the nine factors of the Attribution Questionnaire-9 (AQ-9). Political ideation and political affiliation demonstrated a moderate positive correlation, indicating that people who identified as more conservative also reported affiliation with the Republican Party and those who indicated more liberal views reported affiliation with the Democratic Party. Results showed political affiliation to be significantly correlated with six of the AQ-9 factors: pity, danger, fear, blame, segregation, and anger. Variation in the endorsement of Republican and Democratic political affiliation correlate with differences in the stigmatizing attitudes endorsed. Political affiliation was negatively correlated with pity, danger, and fear, indicating that those affiliated with the Democratic Party endorsed greater attitudes of pity, danger, and fear. Individuals who affiliate with the Republican Party endorsed greater attitudes of blame, segregation, and anger toward people with mental illness represented by the positive correlation among these variables. No significant correlations were found between political ideation and factors from the AQ-9.

Summarized in Table 5 are Pearson product moment correlations between political ideation, political affiliation, and measures of affirming attitudes, specifically the Empowerment Scale, Recovery Scale, and Self-Determination scale. No significant relationships were found between political ideation or affiliation and measures of affirming attitudes.
**Table 3**

*Pearson product moment correlations between participant demographics and factors of the Attribution Questionnaire-9 (N=171).*

<table>
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<tr>
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<td>-.468**</td>
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<td>.197**</td>
<td>.096</td>
<td>.262**</td>
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<td>.272**</td>
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<td>.462**</td>
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<td>.167*</td>
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<td>-.120</td>
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<td>.213**</td>
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<td>.150</td>
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<td>Coer.</td>
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<td>.300**</td>
<td>.378**</td>
<td>.428**</td>
<td>.247**</td>
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</tbody>
</table>

*Note.* Eth. = Ethnicity; Edu. = Highest educational level attained; Pity = Factor from AQ-9; Danger = Factor from AQ-9; Fear = Factor from AQ-9; Blame = Factor from AQ-9; Seg. = Factor from AQ-9 (Segregation); Anger = Factor from AQ-9; Help = Factor from AQ-9; Coer. = Factor from AQ-9 (Coercion); Avoid. = Factor from AQ-9 (Avoidance).

* p < .05  ** p < .01
Table 4

*Pearson product moment correlations between political ideation, political affiliation, and factors of the Attribution Questionnaire-9 (N=171).*

<table>
<thead>
<tr>
<th></th>
<th>PI</th>
<th>PA</th>
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<tbody>
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<td>PI</td>
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<td></td>
</tr>
<tr>
<td>PA</td>
<td>.328**</td>
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*Note.* PI = Political Ideation; PA = Political Affiliation; Pity = Factor from AQ-9; Danger = Factor from AQ-9; Fear = Factor from AQ-9; Blame = Factor from AQ-9; Seg. = Factor from AQ-9 (Segregation); Anger = Factor from AQ-9; Help = Factor from AQ-9; Coercion = Factor from AQ-9; Avoid. = Factor from AQ-9 (Avoidance).

* p < .05   ** p < .01
Table 5

Pearson product moment correlations between political ideation, political affiliation, and measures of Affirming Attitudes (N=171).

<table>
<thead>
<tr>
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<th>PA</th>
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<th>RS</th>
<th>SDS</th>
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</table>

* p < .05   ** p < .01

Note. PI = Political Ideation; PA = Political Affiliation; ES = Empowerment Scale; RS = Recovery Scale; SDS = Self-Determination Scale

Interactions between political affiliation and three demographic variables were examined: gender, race, and income. Table 6 examines Pearson product moment correlations between these interaction variables and factors from the AQ-9. The interaction between political affiliation and gender was significantly negatively correlated with anger, help, and avoidance. The interaction between political affiliation and race was negatively correlated with pity, danger, and fear and positively correlated with blame, segregation, anger, and avoidance. The interaction between political affiliation and income was negatively correlated with pity, danger, and fear and positively correlated with blame, segregation, anger, and avoidance.

Figures 4 through 21 are graphs depicting endorsement of stigmatizing attitudes by political affiliation at different levels of the moderators. With regard to attitudes of pity, there is a greater divide for Republicans by race and a greater split in attitudes for
Democrats by income and gender. For attitudes of both dangerousness and fear, there is a greater impact of race and income on Democrats than Republicans. There is a slightly greater split in attitudes of blame by race for Republicans than for Democrats. There is a much more significant impact of race as a moderator on attitudes of blame for Democrats than for Republicans. For attitudes toward segregation, race was a more impactful moderator for Republicans and income was a bigger moderator for Democrats. With regard to attitudes of anger, there is a greater divide for Democrats by income and gender and a greater impact of race as a moderator for Republicans. There was a slightly greater influence of gender on attitudes of help for Republicans than for Democrats. Help was reverse coded before analysis. Gender, race, and income as moderators had a greater impact on Republicans with regard to attitudes of avoidance.

Subsequent regression analyses were run utilizing political affiliation and the interaction terms that arose as significant in the aforementioned correlations (Table 7). Results indicated that a combination of these factors was significantly associated with six AQ-9 factors: pity, dangerousness, fear, blame, segregation, and anger. With regard to pity, political affiliation and the interaction terms between political affiliation and race and income emerged related indicating that race and income are moderators of political affiliation and that impact of political affiliation with regard to pity depends upon the identified race and level of income of the participant. The interaction term between income and political affiliation arose as significantly associated with dangerousness meaning that income is a moderator of political affiliation in its relationship with attitudes toward dangerousness. With regard to blame, the interaction term between
political affiliation and race emerged as significantly related meaning that race is a moderator. The interaction terms between political affiliation and gender and income emerged as significantly associated with anger indicating that these demographics are moderators and that the impact of political affiliation depends upon the gender and level of income of the participant. No factors emerged as significantly related to fear or segregation.
Table 6

Pearson product moment correlations between political affiliation (PA), interaction terms between PA and demographics, and factors of the Attribution Questionnaire-9 (N=171).

<table>
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<th>PA x race</th>
<th>PA x income</th>
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</thead>
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<td>Avoid.</td>
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<td>.198**</td>
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</table>

Note. PA x gender = Interaction of Political Affiliation and gender; PA x race = Interaction of Political Affiliation and race; PA x income = Interaction of Political Affiliation and income; Pity = Factor from AQ-9; Danger = Factor from AQ-9; Fear = Factor from AQ-9; Blame = Factor from AQ-9; Seg. = Factor from AQ-9 (Segregation); Anger = Factor from AQ-9; Help = Factor from AQ-9; Coercion = Factor from AQ-9; Avoid. = Factor from AQ-9 (Avoidance).

* p < .05 ** p < .01
Figure 4. Graph illustrating attitudes of pity toward people with mental illness by political affiliation, moderated by race.

Figure 5. Graph illustrating attitudes of pity toward people with mental illness by political affiliation, moderated by income.
Figure 6. Graph illustrating attitudes of dangerousness toward people with mental illness by political affiliation, moderated by race.

Figure 7. Graph illustrating attitudes of dangerousness toward people with mental illness by political affiliation, moderated by income.
Figure 8. Graph illustrating attitudes of fear toward people with mental illness by political affiliation, moderated by race.

Figure 9. Graph illustrating attitudes of fear toward people with mental illness by political affiliation, moderated by income.
Figure 10. Graph illustrating attitudes of blame toward people with mental illness by political affiliation, moderated by race.

Figure 11. Graph illustrating attitudes of blame toward people with mental illness by political affiliation, moderated by income.
Figure 12. Graph illustrating attitudes of segregation toward people with mental illness by political affiliation, moderated by race.

Figure 13. Graph illustrating attitudes of segregation toward people with mental illness by political affiliation, moderated by income.
Figure 14. Graph illustrating attitudes of anger toward people with mental illness by political affiliation, moderated by gender.

Figure 15. Graph illustrating attitudes of anger toward people with mental illness by political affiliation, moderated by race.
Figure 16. Graph illustrating attitudes of anger toward people with mental illness by political affiliation, moderated by income.

Figure 17. Graph illustrating attitudes of help toward people with mental illness by political affiliation, moderated by gender.


Figure 18. Graph illustrating attitudes of avoidance toward people with mental illness by political affiliation, moderated by gender.

Figure 19. Graph illustrating attitudes of avoidance toward people with mental illness by political affiliation, moderated by race.
Figure 20. Graph illustrating attitudes of avoidance toward people with mental illness by political affiliation, moderated by income.
Table 7

Regression analyses with political affiliation, demographics, and interaction terms associated with endorsement of stigmatizing attitudes on the Attribution Questionnaire-9 (N=171).

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*Note. PA-Gender = Interaction term—Political Affiliation and Gender; PA-Race = Interaction term—Political Affiliation and Race; Pity = Factor from AQ-9; Danger = Factor from AQ-9; Fear = Factor from AQ-9; Blame = Factor from AQ-9; Segregation = Factor from AQ-9; Anger = Factor from AQ-9; Help = Factor from AQ-9; Coercion = Factor from AQ-9; Avoidance = Factor from AQ-9.  
* P < .05  ** P < .01  *** P < .001
CHAPTER 4

DISCUSSION

Stigmatizing attitudes toward people with mental illness are a significant public health concern that has deleterious effects on the individual. Research has explored ways to expand our conceptualization of stigma to better develop strategies for attitude change in the general public. Further understanding the impact of demographic variables on attitudes may help with exploring future directions for anti-stigma strategies. The purpose of this study was to investigate the impact of political orientation on attitudes toward people with mental illness. This was accomplished by administering questionnaires assessing both stigmatizing and affirming attitudes in an adult community sample.

Before analysis, the data was cleaned, removing cases in which participants identified their political affiliation as being ‘Independent’ or ‘Other’. These groups were included in the data collection so as not to force individuals to choose between one of two major parties. However, the political platforms of these two groups are too eclectic and heterogeneous to draw relevant conclusions; hence, only participants endorsing affiliation with the Democratic or Republican Parties were included in the analyses. When looking at the relationship between the two political orientation variables, it was found that political ideation and political affiliation were significantly correlated. This is consistent with expectation based on the literature; people who foster more conservative views tend to align with the Republican Party and those endorsing liberal views align with the Democratic Party.
It was found that political affiliation correlated with three demographic variables (gender, race, and income), while political ideation did not exhibit a significant relationship with demographics. More women, non-whites, and people who reported making less than $150,000 per year typically identified as affiliating with the Democratic Party while men, whites, and people making $150,000 per year or greater reported more affiliation with the Republican Party. The analysis indicated numerous correlations between the demographic variables and stigmatizing attitudes, including gender, race, education, and income. Women tended to endorse more attitudes of pity and dangerousness, while men endorsed greater attitudes of blame, segregation, anger, help, and avoidance. White participants endorsed more attitudes of blame, segregation, anger, and avoidance, while non-White participants reported greater attitudes of pity, dangerousness, and fear. Individuals with a Bachelor’s degree or higher reported more pity and fear, while participants with lower levels of education reported greater attitudes of blame, anger, help, and coercion. Participants earning less than $150,000 per household per year reported higher levels of pity, danger, and fear, while those earning $150,000 or higher reported greater attitudes of segregation, anger, and coercion.

In assessing the relationship between political orientation and attitudes toward people with mental illness, it was found that there was no significant relationship between affirming attitudes and political ideation or affiliation. It was hypothesized that people who identified as more liberal or affiliated themselves with the Democratic Party would endorse greater affirming attitudes due to the underlying beliefs in humanitarian attitudes, tolerance of varying beliefs, and government action to help individuals. However, in this study, no differences were found in endorsement of affirming attitudes by one’s political
orientation. A relationship was found between endorsement of major political party and differences in stigmatizing attitudes. Individuals affiliated with the Democratic Party endorsed greater attitudes of pity, danger, and fear while those affiliated with the Republican Party endorsed greater attitudes of blame, segregation, and anger. The construct of pity being endorsed in the presence of greater endorsement of dangerousness and fear is not entirely consistent with the literature (Weiner, 1995; Corrigan, 2000). That is, endorsement of attitudes of pity should correlate more highly with helping behavior, not attitudes of dangerousness and fear. However, a possible explanation for this divergence is that pity can be construed as a negative emotion. Literature on perceptions of the homeless in developing countries found that participants who had “pity” for the homeless considered the “sufferer” as inferior, therefore implying a lack of respect to their humanity and dignity (Speak and Tipple, 2006).

Also according to previous research (Weiner, 1995; Corrigan, 2000), attribution of blame for one’s mental illness correlated with increased anger is consistent. However, segregation would be expected to more highly correlate with beliefs of dangerousness and fear, which is not the case with these findings. Given the aforementioned correlations between political affiliation and gender, race, and level of income, there is likely a more complex relationship that explained the correlational relationships between all of these variables. Using the demographic that correlated with political affiliation to create interaction terms, it was found that political affiliation emerged as significantly related to pity, danger, blame, and anger when moderated by other demographics. Race and income were moderators of political affiliation and endorsement of attitudes of pity toward people with mental illness. Level of income moderated the relationship between
political affiliation and attitudes of dangerousness. Race was a moderator of the relationship between political affiliation and blame. Both gender and income were moderators in the relationship between political affiliation and anger.

It was found that there was a greater impact of gender as a moderator of attitudes of pity for Democrats than Republicans, though females tended to endorse less pity overall. As a moderator, race had a larger effect for Republicans than Democrats, though non-white participants generally endorsed greater attitudes of pity regardless of political party affiliation. However, the difference in endorsement of pity by race was greater between white and non-white Republicans than for Democrats. With regard to income, there was less of an impact of the moderator for Republicans than for Democrats in endorsement of attitudes of pity. Individuals with higher levels of income endorsed less pity overall for both parties, but for Democrats, attitudes were more greatly moderated by income than for Republicans. For attitudes of dangerousness, there was a greater impact of race on Democrats than Republicans, with non-whites endorsing higher values on this factor overall. Individuals reporting higher income levels endorsed generally the same attitudes regardless of political party affiliation. However, participants from lower income brackets endorsed greater levels of dangerousness if self-identifying as a Democrat rather than a Republican. When looking at attitudes of fear toward people with mental illness, both race and income as moderators has a greater impact on Democrats than Republicans. Non-whites and individuals in lower income brackets generally endorsed greater attitudes of fear. For attitudes toward segregation, race more greatly moderated Republican attitudes with whites endorsing greater attitudes on this factor overall. Looking at segregation by income, the moderator had a greater impact on
Democrats, with higher income individuals reporting more attitudes of segregation in general. Overall, females reported less anger toward people with mental illness, but the moderator produced a greater split for Democrats than for Republicans. There was a greater impact of income on Democrats than Republicans with individuals from higher income brackets generally endorsing more anger. Democrats with lower income levels reported the lowest levels of anger, while Democrats with higher levels of income endorsed the highest levels of anger. With regard to attitudes of help, males generally reported a greater desire to help, and gender as a moderator had a greater impact on Republicans than Democrats. With regard to attitudes of blame, whites reported greater endorsement overall, with a slightly greater effect of race as a moderator for Republicans. There was a greater split in endorsement of blame by income, particularly for Democrats, with lower income Democrats reporting less blame. Democrats from higher income brackets and Republicans regardless of income reported generally the same amount of blame. Attitudes of blame were also moderated by gender. Females generally endorsed less anger than males regardless of political party affiliation, with the greatest gender moderation effect exhibited for Democrats. Females identifying as Democrats endorsed the lowest levels of blame with a greater difference in attitudes between Democratic females and males than for Republican males and females. Overall, this suggests that endorsement of affiliation with a particular political party alone is not sufficient to understand the relationship with stigmatizing attitudes, but rather varies at levels of other demographic variables.

Given the results discussed above, it is necessary to explore limitations of the study. The recruitment efforts for this study were conducted through Craig’s List and the
resulting convenience sample tended to be relatively anomalous on two factors. First, over 50% of respondents reported ‘Native American’ as their racial background. This likely arose from confusion regarding the two racial options, ‘Native American’ or ‘European/European American’, provided to White participants. Perhaps respondents endorsing ‘Native American’ as their racial origin interpreted the option as a native citizen on America. Unfortunately, given that the racial demographics of our sample are inconsistent with those of the U.S. Census, analyses looking at race as a moderator of political affiliation must be interpreted with caution. Second, participants in this study reported education attainment that lacked diversity, with over 75% attaining at least a Bachelor’s degree. While it may be a byproduct of the recruitment strategy (i.e., perhaps individuals who have attended college are more inclined to use Craig’s List), a more educationally diverse population may provide a better representative sample of attitudes toward people with mental illness.

Additionally, the data collection process for this study was conducted via Qualtrics, an online survey website. While the functionality of Qualtrics met the general requirements for study completion, it is not possible to determine the participants’ level of attention and investment in the study. With regard to questions about political orientation, future studies should include more detailed questions on political ideology. Despite the fact that research supports the single Likert scale question used in this study as being an acceptable stand-alone measure, this study is limited by the lack of insight into different realms of political opinion. For example, inquiring about an individual’s position from liberal to conservative regarding social issues versus economic issues may
have more clearly aided in understanding how this concept is related to stigmatizing and affirming attitudes about people with mental illness.

Future research in this area holds promise for the development of more effective anti-stigma strategies. Replicating this study on a more representative population while compensating for the limitations discussed above would help advance this area of research. Tailoring an anti-stigma intervention to more directly address specific attitudes held by audience members may prove to have longer lasting ameliorative effects. Specifically addressing strongly endorsed attitudes rather than blanket interventions may help to maintain attention longer and enhance perceived relevance to oneself, resulting in greater information retention. For example, focusing heavily on attitudes that are more strongly held by individuals affiliated with the Republican Party, such as blame, segregation, and anger, may have a bigger impact than discussing all aspects of stigma in a single intervention. Literature on political ideology suggests that people have fairly stable attitudes over time that are generally consistent with their political orientation (Sears, 1993) and that one’s orientation greatly impacts his/her attitudes about the world (Crandall & Biernat, 1990). If demographic variables are fairly consistently related attitudes toward people with mental illness, perhaps participants could be screened prior to administration to assign them to an intervention condition that would have the greatest impact on attitudes. Additionally, exploring the impact of an anti-stigma intervention on individuals of different political orientations could help to create interventions that could be more widely digested and disseminated. Speaking directly to one’s personal beliefs rather than generically about stigma as a whole, may prove more effective, particularly with regard to educational interventions.
APPENDIX A

RECRUITING SCRIPT/ADVERTISEMENT
Participate in a study…earn money!

Participate in an online study of social attitudes and the impact of the media on attitudes. You will be asked to either read an article, complete a questionnaire immediately before and following, and an online questionnaire one-week after viewing the video. You must be 18 years of age or older to participate.

All of your responses will be kept confidential and your information will not be used for any other purposes.

As a thank you for participating, you will be compensated $10 over two time points in the form of Amazon.com gift certificates ($5 immediately following participation, and $5 for completing the one-week follow-up).

Click on this link to get started: www.Qualtrics.com/XXXXXXX

Please contact Karina Powell at powekar@iit.edu with questions or concerns.
APPENDIX B

SOCIAL ATTITUDES AND THE MEDIA CONSENT FORM
I understand that my participation in this research project is voluntary and that I may withdraw from the study at any time without penalty. I am aware that my information will be kept confidential. The purpose of this study is to look at knowledge and thoughts about mental health issues.

As a participant in this study, I will spend about 15 minutes completing a questionnaire. I may then be asked to spend about 10 minutes reading a written article and about 10 minutes completing another questionnaire. One-week following my initial participation, I will be asked to spend approximately 15 minutes completing another questionnaire. When I have completed the initial participation, I will receive $5 in the form of an Amazon.com gift certificate emailed to me. When I have completed the one-week follow-up questionnaire, I will receive a $5 Amazon.com gift certificate emailed to me as compensation for my participation.

There are no direct benefits for participating in this study; however the information that is obtained will assist in determining the usefulness of an educational curriculum and the products they produce.

My identifying information will only be used for study purposes. It will not be sold to anyone and it will not be used to contact you regarding another study. This information will be securely stored and will not be accessible to anyone other than the Principal Investigator and Research Assistant.

I understand that this research presents no risks other than what I might feel from thinking about the topic of discussion and the questions that are asked. I understand that a psychologist, Dr. Patrick Corrigan, is available for me to talk to, free of charge, to discuss my situation or my feelings privately. Dr. Corrigan can be contact at (312) 567-6751.

Any further questions about the research and my rights as a participant will be answered if I contact the project director, Dr. Patrick Corrigan, Institute of Psychology, at (312) 567-6751.

This study is funded by The Carter Center in Atlanta, GA, however they are not responsible for any injuries or medication conditions I may suffer during the time I am a research subject.

I understand that the Illinois Institute of Technology is not responsible for any injuries or medical conditions I may suffer during the time I am a research subject unless those injuries or medical conditions are due to IIT’s negligence. I may address questions and complaints to Glenn Krell MPA, CRA, Executive Officer of IIT Institutional Review Board at (312) 567-7141.

I have read the material above and any questions I asked have been answered to my satisfaction. I agree to participate in this activity, realizing that I may withdraw without penalty at any time.

*Please save and/or print a copy of this consent document for your records.
APPENDIX C

DEMOGRAPHICS QUESTIONNAIRE
Demographics Questionnaire

1. Please enter your year of birth: 19__

2. What is your gender? (Please circle one)  Female  Male  Other

3. What is your marital status? (Please circle one)
   Single, Never Married  Married  Widowed
   In a long term relationship  Separated  Divorced

4. What is your race/ethnicity? (Please circle all applicable categories)
   African/African American  Asian/Asian American  Pacific Islander
   European American/American  Native American  Other: ________

5. Are you Hispanic/Latino? (Circle one)  yes  or  no

6. We hear a lot of talk these days about liberals and conservatives. I am going to show you a seven point scale on which political views that people hold are arranged from extremely liberal—point 1—to extremely conservative—point 7. Where would you place yourself on this scale?

   1  2  3  4  5  6  7
   Extremely Liberal  Moderate  Extremely Conservative

7. Please indicate which party you identify with most.
   Democrat  Republican  Independent

8. Is your mother or female guardian still alive? (Circle one)  Yes  No
   a. If so, where would you place her on the following political views scale?

      1  2  3  4  5  6  7
   Extremely Liberal  Moderate  Extremely Conservative

   b. What is her political affiliation?
9. **Is your father or male guardian still alive? (Circle one)** Yes No
   a. If so, where would you place him on the following political views scale?

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   b. **What is his political affiliation?**

   Democrat Republican Independent

10. **What is the highest level of education you have completed?**

    Some high school High school diploma Some college
    Associates degree Bachelor's degree Graduate degree

   a. **If you are currently a student, are you an undergraduate or graduate student?**

    Undergraduate Graduate

   b. **What year of school are you in?**

    1st 2nd 3rd 4th 5th 6th+

11. **What is your own annual income?**

    $0-25,000 $25,001-49,999 $50,000-74,999
    $75,000-99,999 $100,000-124,999 $125,000-149,999
    $150,000-174,999 $175,000-199,999 $200,000-224,999
    $225,000-249,999 $250,000-274,999 $275,000-299,999
    ≥ $300,000
12. **How often do you read/watch/listen to the news?** (Please check one)

_____ Not at all  
_____ 1-2 days per week  
_____ 3-4 days per week  
_____ 4-5 days per week  
_____ 6-7 days per week

13. **What medium do you use most often to keep up with news and current events?**
(Please circle one)

Television   Internet   Radio   Newspaper

14. **What is your current employment situation?** (Circle all that apply)

Full-time   Part-time   Retired   Attending School
Unemployed   Volunteer   Other: ___________________
APPENDIX D

PERSONAL GOALS SCALE QUESTIONNAIRE
**Personal Goals Scale**

Harry is a 35 year-old single man with schizophrenia. Sometimes he hears voices and becomes upset. He lives alone in an apartment and works as a clerk at a large law firm. He had been hospitalized six times because of his illness.

**CIRCLE THE NUMBER OF THE BEST ANSWER TO EACH QUESTION.**

1. Harry will get better after treatment.

   1  2  3  4  5  6  7  8  9
   Strongly Agree
   Strongly Disagree

2. Harry will benefit from medication.

   1  2  3  4  5  6  7  8  9
   Strongly Agree
   Strongly Disagree

3. Harry will benefit from counseling or psychotherapy.

   1  2  3  4  5  6  7  8  9
   Strongly Agree
   Strongly Disagree

4. Harry will benefit from living independently.

   1  2  3  4  5  6  7  8  9
   Strongly Agree
   Strongly Disagree

5. Harry should pursue being a homeowner.

   1  2  3  4  5  6  7  8  9
   Strongly Agree
   Strongly Disagree
6. Harry should pursue a full-time job.

1 2 3 4 5 6 7 8 9
Strongly Agree

7. Harry will benefit from maintaining a romantic relationship.

1 2 3 4 5 6 7 8 9
Strongly Agree

8. Harry would be a competent parent.

1 2 3 4 5 6 7 8 9
Strongly Agree

9. Harry will benefit from traveling.

1 2 3 4 5 6 7 8 9
Strongly Agree

10. Harry should be able to register to use firearms.

1 2 3 4 5 6 7 8 9
Strongly Agree

11. Harry has the capability to become a doctor.

1 2 3 4 5 6 7 8 9
Strongly Agree
12. Harry has the capability to get a Bachelor’s degree.

1 2 3 4 5 6 7 8 9
Strongly Agree

13. Harry has the capability to become an ordained minister.

1 2 3 4 5 6 7 8 9
Strongly Agree

14. Harry would benefit from getting out of the hospital/staying out of the hospital.

1 2 3 4 5 6 7 8 9
Strongly Agree
APPENDIX E

RECOVERY SCALE QUESTIONNAIRE
Recovery Scale

These questions are NOT about Harry. They should reflect your overall opinion about people with serious mental illness in general. Answer them on the nine point scale (1=strongly agree, 9=strongly disagree).

1. People with mental illness have goals in life that they want to reach.

   1 2 3 4 5 6 7 8 9
   Strongly        Strongly
   Agree            Disagree

2. People with mental illness believe that they can meet their current personal goals.

   1 2 3 4 5 6 7 8 9
   Strongly        Strongly
   Agree            Disagree

3. People with mental illness have a purpose in life.

   1 2 3 4 5 6 7 8 9
   Strongly        Strongly
   Agree            Disagree

4. Even when people with mental illness don’t care about themselves, other people do.

   1 2 3 4 5 6 7 8 9
   Strongly        Strongly
   Agree            Disagree

5. Fear doesn’t stop people with mental illness from living the way they want to.

   1 2 3 4 5 6 7 8 9
   Strongly        Strongly
   Agree            Disagree
6. Something good will eventually happen.

1  2  3  4  5  6  7  8  9
Strongly Agree

7. People with mental illness are hopeful about their future.

1  2  3  4  5  6  7  8  9
Strongly Agree

8. Coping with mental illness is not the main focus of the lives of people with mental illness.

1  2  3  4  5  6  7  8  9
Strongly Agree

9. The symptoms that people with mental illness experience interfere less and less with their life.

1  2  3  4  5  6  7  8  9
Strongly Agree

10. The symptoms that people with mental illness experience are a problem for shorter periods of time each time they occur.

1  2  3  4  5  6  7  8  9
Strongly Agree

11. People with mental illness have people they can count on.

1  2  3  4  5  6  7  8  9
Strongly Agree
12. Even when people with mental illness don’t believe in themselves, other people do.

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13. It is important to have a variety of friends.

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APPENDIX F

EMPOWERMENT SCALE QUESTIONNAIRE
Empowerment Scale

Instructions: Below are a few statements relating to one’s perspective on life and with having to make decisions. Please circle the number above the response that is closest to how you feel about the statement. Indicate how you feel now. First impressions are usually best. Do not spend a lot of time on any one question. Please be honest with yourself so that your answers reflect your true feelings.

PLEASE ANSWER ALL QUESTIONS
BY CIRCLING THE NUMBER THAT BEST DESCRIBES HOW YOU FEEL.
PLEASE CIRCLE ONLY ONE.

1. I feel people with mental illness are persons of worth, at least on an equal basis with others.

   1 2 3 4 5 6 7 8 9
   Strongly Agree
   Strongly Disagree

2. I see people with mental illness as capable people.

   1 2 3 4 5 6 7 8 9
   Strongly Agree
   Strongly Disagree

3. People with mental illness are able to do things as well as most other people.

   1 2 3 4 5 6 7 8 9
   Strongly Agree
   Strongly Disagree
APPENDIX G

ATTRIBUTION QUESTIONNAIRE
Recall the vignette about Harry: Harry is a 35 year-old single man with schizophrenia. Sometimes he hears voices and becomes upset. He lives alone in an apartment and works as a clerk at a large law firm. He had been hospitalized six times because of his illness.

**Attribution Questionnaire**

CIRCLE THE NUMBER OF THE BEST ANSWER TO EACH QUESTION.

1. I would feel pity for Harry.

   1  2  3  4  5  6  7  8  9
   none at all  very much

2. How dangerous would you feel Harry is?

   1  2  3  4  5  6  7  8  9
   none at all  very much

3. How scared of Harry would you feel?

   1  2  3  4  5  6  7  8  9
   none at all  very much

4. I would think that it was Harry’s own fault that he is in the present condition.

   1  2  3  4  5  6  7  8  9
   none at all  very much

5. I think it would be best for Harry’s community if he were put away in a psychiatric hospital.

   1  2  3  4  5  6  7  8  9
   none at all  very much

6. How angry would you feel at Harry?

   1  2  3  4  5  6  7  8  9
   none at all  very much
7. How likely is it that you would help Harry?

1  2  3  4  5  6  7  8  9
definitely  definitely
would not help  would help

8. I would try to stay away from Harry.

1  2  3  4  5  6  7  8  9
none at all  very much

9. How much do you agree that Harry should be forced into treatment with his doctor even if he does not want to?

1  2  3  4  5  6  7  8  9
none at all  very much
BIBLIOGRAPHY


