Influence of Contact and Subjective Social Status on Stigma and Benevolence Toward Individuals with Bipolar Disorder

Research Project for Psychology Program Distinction

Presented to

The Psychology Program

Stockton University

Gianna Zammarelli

April 2021

COMMITTEE MEMBERS

Committee Chair: Christine Ferri, Ph.D.

_____

Committee Chair Signature

Committee Member: Mark Berg, Ph.D.

_____

Committee Member Signature

Committee Member: Kaite Yang, Ph.D.

_____

Committee Member Signature

Abstract

Stigma negatively impacts perceptions of individuals who have mental illnesses, and in turn, contributes to self-stigma, unwillingness to seek treatment, and unwillingness to have a relationship with a person who has a mental illness

treatment especially when hospitalization, outpatient treatments, and comorbid conditions are applicable (Bessonova et al., 2020). However, effective treatments are available, and an individual with bipolar disorder can expect a normal level of functioning when the proper treatment is utilized. Upon return to regularly scheduled activities after treatment/hospitalization has been completed, fear of stigma and judgment could result in the individual not returning to previous careers and/or activities once enjoyed. Stigma causes a distressing burden on those with mental illness, affecting their willingness to seek treatment, causing a decrease in their self esteem and increase in the severity of their symptoms (Cuttler & Ryckman, 2019).

Cassidy and Erdal (2020) showed that interventions focused on exposure and education about the effective treatments for individuals with bipolar disorder reduced stigmatic attitudes in participants. They discovered that stigma was reduced when information was given to the participants regarding causal factors for bipolar disorder, namely biological factors which are out of one's control (Cassidy & Erdal, 2020). In addition to educational intervention, changing language is also associated with reductions in stigma. Ellison et al. (2015) studied the effect of renaming bipolar disorder as 'manic depression' and schizophrenia to 'integration disorder;' this study also measured public stigma. Renaming disorders elicited more fear responses and did not

of mental illness. Higher subjective SES was associated with higher levels of prejudice for depression and mental illness (nonspecified), though not for schizophrenia. Interestingly, the lower socioeconomic status reported correlated with more knowledge about the mental illnesses. The more the knowledge about mental illness, the higher the empathy (Foster et al., 2018).

Stigma and Subjective Social Status in Elite College Culture

Billings (2020) studied personal and perceived stigma in college students from an elite (Ivy League) and a non-elite (non-Ivy League) private college. Significant findings include that Ivy League students showed greater personal stigma about mental illness than non-Ivy League university students. In the elite institution, experience with mental illness for self or a family member was associated with less stigma, which is consistent with contact theory. In the elite institution, subjective social status was a predictor of both perceived and personal stigma, with lower social status associated with more stigma. At the non-elite institution, higher social status was associated with more stigma. In both institutions, lower status students are more likely to have psychological disorders and not receive any treatment due to the stigma surrounding the college community (Billings, 2020; Eisenberg et al., 2007; Hunt & Eisenberg, 2010; Rosenthal & Wilson, 2008). Billings (2020) found that students who were of low socioeconomic status were more likely to exhibit empathetic behavior and understand the struggles of their family and friend's who may be experiencing mental illnesses (Billings, 2020). Context seems to matter, and subjective social status is associated with stigma, but might depend on whether lower status individuals feel particularly excluded in an elite setting.

The present study will contribute to the literature by learning more about how contact, and social status are associated with stigma and benevolence. The current study will examine

CONTACT

Benevolence was measured using a subscale of the Community Attitudes towards the Mentally Ill scale.

participants to visualize where they can see themselves in contrast to either the country or community. Regression analysis was conducted for the first item of the MacArthur Scale of Subjective Social Status- Adult version scale (comparison to the United States) was used in the analyses for this paper (see Appendix C). Both questions were tested separately using regression analysis, but when combined, yielded null results.

Procedure

Participants participated through Stockton University's SONA psychology lab by signing up for an available time slot to complete the study, and had access to the online survey Qualtrics link. The first page of the survey on Qualtrics was a consent form and participants who consented to the study for participation gained access to the study. Participants were asked various demographic questions, as well as if they have any contact with an individual who has bipolar disorder, and if they do or do not have bipolar disorder themselves. Anyone who reported that they had been diagnosed with bipolar disorder were excluded from the study. Data was collected for two weeks from March 19th to April 2nd, 2021.

Statistical Analysis

Two independent samples t tests were used to test differences in stigma and benevolence for those with and without contact with a person who has bipolar disorder, specifically testing contact theory in both hypothesis 1 and hypothesis 2. Two regression analyses were conducted, with the MacArthur Scale of Subjective Social Status scale as the independent variable, and benevolence and also stigma as the dependent variables.

Results

In the sample (n=71), n=58 were female (81.6%), n=6 were male (8.4%), n=2 were non-binary (2.8%), and n=1 was not applicable (1.4%). There were n=4 participants who did not

consent to completing the study (5.6%). The mean age was ***M***= 20.34 (***SD***=3.18) and 69% of the sample was made up of participants aged between 18-20 years old. Most of the participants were psychology majors (n=35, 49.1%), with a range of majors including biology, criminal justice, health science, social work, and other fields participated in this study.

Ten participants (14.9%) reported that they had bipolar disorder themselves and were excluded from further analyses. Out of n=57 who answered the question about contact with someone who has bipolar disorder, n=33 participants (57.9%) did report knowing someone with bipolar disorder.

The mean score on the 10 point scale of subjective social status was ***M***=5.39, ***SD***=1.38. This was a sample that overall identified as middle class.

Hypothesis 1 stated that participants who know someone with bipolar disorder would have less stigma than those who did not know someone with bipolar disorder. This hypothesis was not supported; there was not a significant difference in stigma scores for individuals who have contact with someone who has bipolar disorder (***M***=12.93, ***SD***=6.21) compared to someone who does not have contact with someone with bipolar disorder (***M***=8.63, ***SD***=8.38; t(23) = 11.473, p>0.05, 95CI [-10.632, 1.74)].

Hypothesis 2 stated that contact would be associated with more benevolence. This was supported; individuals who know someone who has bipolar disorder (***M***=43.38, ***SD***=4.93) scored higher on benevolence than those who do not know someone with bipolar disorder (***M***=40.04, ***SD***=5.55; t(53) = -2.362, p<.05, 95CI [-0.505, -6.19]).

Hypothesis 3 stated that individuals with higher subjective social status would have higher levels of stigma. This was supported; subjective social status compared to others in the United States was significant as a predictor of stigma, β=2.194, t(23)=0.483, p<.05. Subjective

and therefore we can most accurately conclude that the higher a person's social status, the more aware they are of the mental health stigma existing within their communities.

Hypothesis 4 showed that subjective social status is not predictive of benevolence toward those who have bipolar disorder, β=0.615, t(53)= 1.347, p>.05. Subjective social status did not explain a significant portion of the variance in benevolence scores, ^{2}***=.033, F(1,53)=1.1815, p=.184***. The results of this study are important, since an individual's subjective social status is not indicative of how kind (benevolent) they are toward individuals with bipolar disorder, but shows they are aware of the stigma that exists toward people with bipolar disorder at the very least. In contrast to this study, Ahuja et al. (2017) utilized the CAMI scale and found significant increases in a participant's benevolence and social restrictiveness in their pre and post one week educational interventions and assessments of their sample. With this, education about mental illness is proven to show desirable results toward the reduction of stigmatic attitudes and perceptions of individuals with mental illnesses. It is with hope in the future that individuals continue to advocate for the reduction of mental health stigma regardless of an individual's SES. Awareness that the stigma exists is an important first step in making an impactful difference in society.

Limitations

One problem with this study was the high rates of missing data from participants, especially for the stigma items, in which just 25 participants completed the full scale. This may explain the null results. It is notable that with a larger sample of complete data for benevolence (n=55), significant results were obtained in the hypothesized direction. Future research with

incentive to participate in research (i.e. monetary reward) may have resulted in a more complete data set and more participants.

The sample was undergraduate college students and therefore not generalizable to the rest of the population. If this study were conducted differently or continued as a replication study in the future, the research team could include graduate students, community members, and more variety in age and socioeconomic status. The amount of education in psychology and personal experience can be indicative of a person's empathic nature, and may influence the results.

Additionally, a more nuanced assessment of stigma, especially personal stigma, should be included in future research. Perceived stigma, or community stigma, was measured in this study, however, both perceived and public stigma would create more meaningful conclusions about mental health stigma in an individual and identify targets for interventions to reduce stigma.

Another limitation of this study was the small sample size that could have been enlarged by length of data collection. Type of relationship could also influence contact's impact on stigma and benevolence, and could be further explored in future investigations. Lastly, this study's sample was made up of mostly females, middle social status, and young adults. In future investigations, if subjective social status is explored, there should be a more diverse sample. Perhaps comparing and contrasting Stockton University to Atlantic Cape Community College or other undergraduate institutions could be useful for generating meaningful results when a mix of socioeconomic backgrounds and ages are applicable, which could result in more data participation and give credibility due to the larger population.

Conclusion

This study demonstrates the importance of understanding attitudes about people with bipolar disorder in a sample of college students. By including both stigma and benevolence, we

can learn more about negative as well as positive outcomes measures, which is an important goal of the field of positive psychology. It is important to discuss and spread awareness about mental health in order to recognize how to dismantle the barriers of stigma as well as enhance empathy towards those with a mental illness. Contact with someone who has a mental illness can impose benevolence toward not only the individual who they know has a mental illness, but may also spread this empathy to other individuals in the community who have a mental illness. More recently, there has been an improvement of societal acceptance in talking about mental illness, which individuals are more willing to talk about mental illnesses (Lipson et al., 2018). In today's society, there is wider acceptance for individuals regardless of their backgrounds, which could positively influence a reduction of stigma (i.e. no tolerance allowed for prejudice toward an individual's SES when applying for a job). Perhaps with increased awareness and honest conversations about experiences with mental illnesses we will realize that most of us do know someone with mental illness and can express benevolence toward them. Further research with stigma reduction will promote benevolence and awareness of mental health to the population, aiding in the goal to ultimately eradicate the stigma of mental illness. Acceptance can be the glue that reconnects the severed barriers created by stigma between individuals with mental illness and those who do not have a mental illness.

References

Adler, N. E., Epel, E. S.,Castellazzo, G., & Ickovics, J. R. (2000). Relationship of subjective and objective social status with psychological and physiological functioning: Preliminary data in healthy, White women. ***Health Psychology, 19***(6), 586-592.

Ahuja, K. K., Dhillon, M., Juneja, A., & Sharma, B. (2017). Breaking barriers: An education and contact intervention to reduce mental illness stigma among Indian college students. ***Psychosocial Intervention, 26***(2), 103–109.https://doi-org.ezproxy.stockton.edu/10.1016/j.psi.2016.11.003

Allport, G. W. (1954). ***The nature of prejudice.*** Addison-Wesley.

Bessonova L, Ogden K, Doane MJ, O'Sullivan AK, Tohen M. (2020). The economic burden of bipolar disorder in the United States: A systematic literature review. ***Clinicoecon Outcomes Res***. doi: 10.2147/CEOR.S259338. PMID: 32982338; PMCID: PMC7489939.

Billings, K. R. (2020). Stigma in class: Mental illness, social status, and tokenism in elite college culture. ***Sociological Perspectives.*** https://doi.org/10.1177/0731121420921878

Byrne, P. (2000). Stigma of mental illness and ways of diminishing it. ***Advances in Psychiatric Treatment, 6***(1), 65-72. doi:10.1192/apt.6.1.65

Cassidy, C., & Erdal, K. (2020). Assessing and addressing stigma in bipolar disorder: The impact of cause and treatment information on stigma. ***Stigma and Health, 5***(1), 104–113.

Corrigan, P.W. & Watson, A.C. (2002). Understanding the impact of stigma on people with mental illness. ***World Psychiatry, 1***(1), 16-20. https://doi-org.ezproxy.stockton.edu/10.1037/sah0000181

Cuttler, C., & Ryckman, M. (2019). Don’t call me delusional: Stigmatizing effects of noun labels on people with mental disorders. ***Stigma and Health, 4***(2), 118–125.

https://doi-org.ezproxy.stockton.edu/10.1037/sah0000132

Lipson, S.K., Lattie, E.G., Eisenberg, D. (2018) Increased rates of mental health service utilization by U.S. college students: 10-Year Population-Level Trends (2007–2017). ***Psychiatric Services***, 10.1176/appi.ps.201800332

National Institute of Mental Health (2021). ***Mental Illness.*** Retrieved December 17, 2020, from https://www.nimh.nih.gov/health/statistics/mental-illness.shtml

Pettigrew, T. F., & Tropp, L. R. (2006). A meta-analytic test of intergroup contact theory. ***Journal of Personality and Social Psychology***, ***90***(5), 751–783. https://doi-org.ezproxy.stockton.edu/10.1037/0022-3514.90.5.751

Phelen, J.E. & Bassow, S.A. (2007). College students' attitudes toward mental illness: An examination of the stigma process. ***Journal of Applied Social Psychology***, ***37***(12), 2877-2902. https://doi.org/10.1111/j.1559-1816.2007.00286.x

Phelan, J. C., Lucas, J. W., Ridgeway, C. L., & Taylor, C. J. (2014). Stigma, status, and population health. ***Social Science & Medicine*** (1982), ***103***, 15–23. https://doi.org/10.1016/j.socscimed.2013.10.004

N˜ Applied

Appendix A

STIGMA-EMIC (community version)

We are trying to conduct research in order to identify the needs of people with bipolar disorder in the area. Please answer the following short questions about the views of the community regarding bipolar disorder.

x. Local residents have good reason to resist the location of mental health services in their neighborhood.
y. The best way to handle the mentally ill is to keep them behind the locked doors.
z. Our mental hospitals seem more like prison than like places where the mentally ill can be cared for.
aa. Anyone with a history of mental problems should be excluded from taking the public office.

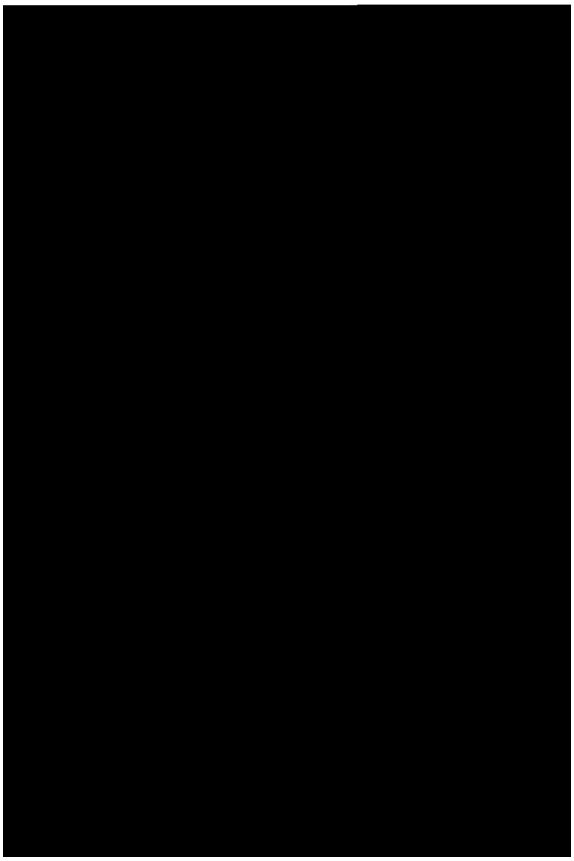
Appendix C

MacArthur Scale of Subjective Social Status - Adult Version

Instructions: Think of this ladder as representing where people stand in the United States. At the top of the ladder are the people who are the best off – those who have the most money, the most education, and the most respected jobs. At the bottom are the people who are the worst off

Instructions: Think of this ladder as representing where people stand in their communities. People define community in different ways; please define it in whatever way is most meaningful to you. At the top of the ladder are people who have the highest standing in their community. At the bottom are the people who have the lowest standing in their community.

Where would you place yourself on this ladder?



Please select a number, 1-10, pertaining to the rung where you think you stand at this time in your life relative to other people in your community.