# The Perception of Mental Illness: A Cross-Cultural Comparative Study

Chassidy R. Overstreet

Tennessee Technological University

**Abstract**

Research indicates that people often have negative perceptions towards those with a mental disorder. Otto (1999) concluded that when mental health consumers ($N$ = 1,301) self-reported how they experience stigma; they were commonly hurt by "stigmatizing comments of depictions of mental illness" with 80% overhearing hurtful comments about mental illness. The current study examined perception of mental illness and attributions made about those with a mental health diagnosis. Three-hundred and nine American and International students completed online stigma related questionnaires: The Beliefs towards Mental Illness Questionnaire (BMI), Perceived Stigma Questionnaire (PSQ), and The Inventory of Attitudes Toward Seeking Mental Health Services (ATSMHS), the Physicians Trust Scale, and the Short Schwartz Value Survey (SSVS). Separate multiple regression analysis were performed on the BMI and PSQ, with personal relationship, respondents' gender and ATSMHS, and SSVS as predictors using the backward elimination method. PSQ scores resulted in a best prediction equation PSQ= -.068 (Personal Relationship) + 3.38. Regression analysis of BMI scores yielded a best prediction equation of BMI = 4.27(Personal Relationship)-2.07(Gender) + .05(Power) + .03(Achievement) - .05(Self-Direction) + 1.67. This result suggests those who *do not* personally know someone with a mental illness, males, those who place more importance on the values of Power and Achievement, and place less importance on the value of Self-Direction report significantly greater stigma towards those diagnosed with mental illnesses. These findings emphasize the importance of personal contact, the significance of cultural values, and how cultural transmitters such as popular media, enculturation processes, and cultural differences require future research.

*Keywords: cross-cultural, mental illness, stigma, cultural values,*

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## Introduction

### The History of the Mental Illness Stigma

The history of mental illness, or "madness" has a long and dark history which dates back to at least 5,000 BC, as archeologists have found human skulls with small round holes in them, in which it was thought these holes were used to release any demonic spirits (Porter, 2002). To many, mental illness was considered religious punishment for those whom committed sin, however in more extreme cases people were even diagnosed with demonic possession. This connection to religion could likely be linked to the Bible verse from the book of Deuteronomy (6: 5) where it is written, "The Lord will smite thee with Madness". In ancient Mesopotamia times, priest-doctors also believed mental illness derived from demonic possession, and tried to drive out these demons using exorcisms, prayer and sometimes even attempted to use human devices such as punishment, threats, and bribery (Foerschner, 2010). Due to the stigma attached to mental illness, the people whom society considered mentally ill were often shunned by their communities and even rejected by their families, which left them to fend for themselves on the streets, up until the mass establishment of asylums. The most infamous monastery, Saint Mary of Bethlehem, was converted to an asylum in 1547. The institution soon earned the nickname "Bedlam" as it was revealed that the psychotic and violent patients were put on display like sideshow freaks for the public to peek at for the price of one penny, as the calmer patients were put on the streets to beg for charity (Butcher et al, 2007).

In the late 1800's, we're introduced to Sigmund Freud, an Austrian neurologist and psychiatrist who developed the Psychoanalytic Theory. Although many critics considered it a pseudoscience, Freud believed that mental illness was caused by the battle inside your mind as

the ego attempted to please both the id and the superego (Foerschner, 2010). In the 1900's the development of electroconvulsive therapy, psychosurgery, and psychopharmacology were introduced as a biological model of mental pathology. Electroconvulsive therapy sent electrical currents through one's head in the attempt to provide a "hard reset" on the mind and to ease or eliminate mental illness symptoms all together. Despite it being used as a scare tactic in the past, electroconvulsive therapy is used today for patients with severe depression with psychotic symptoms (Foerschner, 2010). Into the 1930's and throughout the 1950's, psychosurgery or lobotomies were introduced to the field. Lobotomies were short 10 minute procedures and were generally for patients who were very violent and emotional as a way to try to ease and calm them. Patients were first shocked into a coma, then a surgeon hammered an icepick-like tool into the eye sockets to sever the nerves connecting the frontal lobes to the emotion regions on the inner brain. At first this procedure was successful, however it wasn't until tens of thousands of patients endured this procedure were the damaging effects recognized as they were unnaturally calm (Foerschner, 2010). Yet another failure, the search for a treatment for mental illness continued.

In 1959, the concept of psychopharmacology was introduced by Australian Psychiatrist J.F.J Cade with the drug Lithium, which was able to control the symptoms of psychosis. Psychopharmacology and the use of psychoactive drugs was a substantial advancement in the field of psychology and mental health, although it also caused a huge problem. Patients with a mental illness almost always choose the drug option as a way to avoid dealing with their mental illness, as opposed to counseling or cognitive-behavioral therapy (Foerschner, 2010). In the late 1990's pharmaceutical companies assured the medical community that patients would not become addicted to prescription opioid pain relievers, and healthcare providers began to

prescribe them at greater rates. Before learning how addictive opioids were, the excess over prescriptions lead to widespread misuse of opioid medication creating the devastating opioid epidemic we know of today (Opioid Crisis, 2017). It's apparent that drugs can't solve all of our problems, and may even create new ones, although new technologies are being developed every day. Clinical psychologists are even using virtual reality technology to treat patients who have been diagnosed with Post-Traumatic Stress Disorder (PTSD). From punishment from God, demons and exorcisms, a battle from within, hard conditions, electroconvulsive shock, lobotomies to psychotropic drugs, the mental health field has a dark past, which is likely connected to why mental health has a bad name. The history had a huge impact on why people see mental illness in certain perspectives, and is important as the current study sought to look at cross-cultural variation. However, it is a necessity to analyze prior research in relation to the mental health stigma and how it is perceived by other cultures/countries.

**Cross-Cultural/Countries and the Stigma of Mental Illness**

It is important to know the history of mental illness to reach a better understanding of why there is a stigma. In a study from 1999, researcher Otto F. Wahl distributed a nationwide survey to 1,301 participants in hopes of collecting information of how mental health consumers experience stigma. The survey sent out was created using information of commonly reported stigma experiences from first-person experiences obtained from *Schizophrenia Bulletin* and the *Journal of the California Alliance for the Mentally Ill.* Also, information was collected from the National Alliance for the Mentally Ill (NAMI) and feedback was given to create the survey used in this study. The survey measured and evaluated three sections of questions; Stigma, Discrimination, and Demographics. Participants used print and electronic sources, as the survey was published in an issue of the NAMI newsletter, *The Advocate*, NAMI Consumer Council

members were given packets to distribute to consumers in other locations and the survey was posted on the NAMI website and were selected through random sampling and interviewed to assure the validity of the participant group (Otto, 1999). The survey reached 49 states, Canada, and Ireland. Participant ages ranged 12-94, with the average of 42, and consisted of mostly single (46%), female (56%), predominantly Caucasian (80%), and tended to have some college education. Participants were diverse in reference to their diagnoses: bipolar disorder (25%), schizophrenia (19%) and depression (15%) (Otto, 1999).

These participants were asked questions about stigma and discrimination experiences. In reference to stigma, participants were commonly hurt by "witnessing stigmatizing comments of depictions of mental illness" with almost 80% overhearing hurtful or mean comments about mental illness. Furthermore, 7 out of 10 respondents noted that they had been treated less than competent by others who knew their illness. More than half (60%), had experienced being shunned or avoided. Therefore, it is not shocking that 74% of participants had sometimes, often or very often avoiding telling others about their mental illness. In contrast, there were few reports of discrimination in the workplace, volunteering positions or housing applications, however this could be due to the 70% of participants reported that they had sometimes, often, or very often abstained from including their mental illness on such applications (Otto, 1999). The results are relevant in that it shows that consumers of mental illness services are embarrassed of their status and that they feel judged and stigmatized by it, to the extent of hiding their status from others. This data demonstrates that stigma is real and people should be more conscious in how they judge others; how much about the illness do they know that is factual? In relation to the current study, a limitation this study has is that it only includes three countries; the U.S., Canada, and Ireland. In addition, the study is 18 years old and the data may have changed since then.

In a 2012 study, researchers Bobby K. Cheon and Joan Y. Chiao, too wanted to analyze the mental health stigma, however included cultural variation to account for the differences. The study strived to compare implicit and explicit attitudes towards mental illness between Asian American and Caucasian American students. Participants consisted of forty Caucasian students, and forty Asian American students (20 Chinese, 19 Korean, and 1 multiracial Chinese-Korean). Of the Asian American students, 24 were born in the U.S. and 16 were born in either China or Korea, however all were fluent English speakers, as the information was presented in English (Cheon, 2012). Participants practiced a categorization task, in which they were to place certain words in either the physical illness category or the mental illness category. This practice helped the students reach a better understanding of what was expected of them during the Go/No-Go Association Task (GNAT). The Go/No-Go Association Task (GNAT) is used as a way to measure implicit and explicit attitudes towards mental illness, as the participants categorized the words appropriately by either making or inhibiting a response (Cheon, 2012).

The results showed no significant differences between the reaction times and error rates of the two different groups, meaning that participants clearly understood what words were categorized as physical illness and those considered mental illness. However, comparison of the GNAT showed that Asian Americans occupied a significantly stronger bias toward mental illness relative to Caucasian Americans. In contrast, the groups did not significantly differ in their implicit biases toward physical illness (Cheon, 2012). The researchers assumed these differences were due to the cultural variations between the two groups. In addition, it was suggested that the cultural differences in the meaning and stigma associated with mental illness varies. These findings are relevant to the current study because if there is a difference between Asian Americans and Caucasian Americans, there may also be differences between other cultures and

countries. This study may be evidence that culture shapes how people perceive and receive mental illness.

**Cross-Cultural/Countries and Help-Seeking Behaviors**

In a 2010 cross-cultural/country study, researchers asked themselves; what are the prevailing attitudes towards mental health help-seeking in Europe? What correlates with these attitudes and to what extent are these attitudes associated with actual service use for mental health problems? Researchers collected data from the European Study of Epidemiology of Mental Health Disorders (ESEMHD), which is a cross-sectional survey that represents the adult population of six European countries: Belgium, France, Germany, Italy, the Netherlands and Spain ($N$ = 21,425). Randomly selected participants were randomly selected and interviewed as long as they were 18 years or older, and fluent in the language of administration. Researchers used the World Mental Health Composite International Diagnostic Interview (CIDI) to assessed participants' diagnosis, service use, socio-demographics, and attitudes towards mental health help-seeking (Ten Have et al, 2010). The survey used to measure attitudes towards mental health help-seeking, on a 5-Likert scale, and asked questions such as "If you had a serious emotional problem, would you go for professional help?" and "How embarrassed would you be if your friends knew you were getting professional help for an emotional problem?" on a 5-Likert scale. The correlates assessed and recorded included; socio-demographic characteristics, mental disorders, emotional role impairments, parental psychiatric use, and service use (Ten Have et al, 2010).

The results of attitudes towards mental health help-seeking, in total, showed that "88.2% of the Spaniards and 80.5% of the Italians would probably or definitely go for professional help in case a serious emotional problem arose", however other countries such as Belgium (56.8%)

and Germany (65.4%) were noticeably lower. In addition, “90.3% of the Spanish respondents would not be very or at all embarrassed if their friends knew they were getting professional help for an emotional problem”. In the other countries, this ranged from 73.1% (Italy) to 81.5% (Belgium). Generally, the participants were much less favorable in the effectiveness of professional help. The correlates of attitudes toward mental health help-seeking showed that the higher income, females who were younger than 65, and living in Spain or Italy were more likely to seek help when faced with an emotional problem, than their counterparts in comparison to the average European. In conclusion, attitudes towards mental health help-seeking significantly correlated with actual service use (Ten Have et al, 2010), therefore, it is to be assumed that “almost a third of all respondents believed that professional care was worse than or to no help when faced with a serious emotional problem” (Ten Have et al, 2010). This study is relevant to the current study as it provides evidence that cultural perception of mental health service may lead to less or more actual service use.

In a 2014 study, Rachel A. Vidourek and colleagues, sought to examine the benefits and barriers to mental health help-seeking. Their research questions included the following: What are perceived benefits and barriers to mental health help-seeking behaviors among college students? Do college students hold negative or stigmatized attitudes toward receiving services? Lastly, do perceived benefits, barriers, and stigma-related attitudes differ based on sex, grade, race/ethnicity, involvement in a campus organization, and/or having a friend or family member with a mental health disorder? (Vidourek et al, 2014). All 682 participants were English speaking students collected from general education, health, fitness and leisure classes at a Midwestern university in the United States. Participants were 62.3% female, predominantly Caucasian (77.8%) and 38.1% had a family member or friend with a diagnosed mental health disorder. The

grade level ranged from freshman (37.6%), sophomores (26%), juniors (17.8%), seniors (17.6%) and 1% were graduate students (Vidourek et al, 2014). The survey, created from the Health Belief Model, was used to examine health help-seeking behaviors and contained four parts. Part one, with 14 items, assessed college students perceived benefits to seeking treatment for a mental health problem in a check all that may apply format. Part two, with 14 items, assessed students perceived barriers to seeking treatment for a mental health problem in a check all that may apply format. Part three, with 6 items, aided in determining the perceived stigma to mental health disorders and treatment in a 5-point Likert-type scale (1=strongly disagree and 5=strongly agree). Lastly part four, with 11 items, measured background and demographics in a fill in the blank and check box format.

Results showed that improved mental health, reduced stress, and resolving one's problems were the top three benefits of help-seeking. Furthermore, students with a family member or friend with a mental health disorder perceived a significantly higher number of benefits than their counterparts. Students who had received mental health counseling perceived significantly more barriers to help-seeking than those who has not received mental health counseling (Vidourek et al, 2014). The researchers found that the variable of stigma related to attitudes showed that students disagreed or strongly disagreed that individuals who go to counseling are: mentally weak, crazy, should handle their own problems, unable to handle their own problems, lazy, and/or different from normal people in a negative way. Students who had a family member or friend diagnosed with mental health disorder were significantly less likely to hold stigma-related attitudes than their counterparts. Also, students who had received counseling were perceived significantly less stigmatized than those who has not received mental health counseling (Vidourek et al, 2014). This study is relevant to the current study as it consists of

college student participants and it pertains to help-seeking behaviors and how stigma may have an impact on whether one might seek help. In addition, it is important to research other variables that may have an impact on the dependent variables; stigma and help-seeking behaviors. A question to consider is; does Medical Mistrust play a role in whether or not someone seeks mental health help?

**Medical Mistrust**

The famous 1932 Tuskegee Study may have led to generations of African-Americans to be weary of participation in research. The original paper "Tuskegee Study of Untreated Syphilis in the Negro Male" could not be found, therefore the following information is from the Centers for Disease Control and Prevention webpage (CDC, 2015). In 1932, researchers wanted to record the "natural history of syphilis in hopes of justifying treatments programs for blacks" (CDC, 2015). Participants consisted of 600 black men; 399 with syphilis and 201 without, in whom all "agreed freely to be examined and treated" and whom may have been persuaded with incentives such as free medical exams, free meals, and burial insurance (CDC, 2015).

This study is considered unethical as the researchers did not provide the participants with the true purpose of the study and misled them, therefore without all facts, the participants could not provide informed consent. In addition, the researchers only told the participants that they were being tested for "bad blood", not that syphilis specifically was being tested, and were never given proper treatment for their disease, even after 1947 when penicillin was found as a cure.

In a 2016 study, researchers hypothesized that racial micro aggressions would lead to Medical Mistrust and be associated with mental health (anxiety, depression, and well-being). In addition, researchers hypothesized that racial micro aggressions would significantly and positively predict Medical Mistrust, which would lead to significantly negative help-seeking attitudes (Kim

et al, 2016). The participants consisted of 156 Asian American undergraduate students (39 who had experienced counseling), in which Chinese, Filipino, Korean, Japanese, Vietnamese, Taiwanese, Cambodian, Indian, Indonesian, Laotian, Hmong, and Thai ethnicities were represented. Participants were presented with five surveys to complete. The demographics survey assessed gender, ethnicity, and place of birth, years lived in the U.S., school year, and counseling experience. Participants completed the Racial and Ethnic Micro aggressions (REMS) which is a 45-item scale that was used to assess racial and ethnic micro aggressions. Participants also completed the Medical Mistrust Inventory (CMI), a 47 item survey that analyzes interpersonal relations, education and training, business and work, and politics and law, which was modified to asses Asian Americans, instead of African Americans. In addition, The Anxiety, Depression, and Psychological Well-Being (PWB), a 27 item inventory, was used to assess mental health outcomes. Lastly, participants completed The Attitudes Toward Seeking Professional Psychological Help-Short Form (ATSPPH-SF), a 10 item instrument, which was used to assess attitudes towards seeking help.

The results showed that racial micro aggressions demonstrated reduced well-being through Medical Mistrust. The researchers found that an increase in micro aggression experience related to an increase in mistrust, which lead to decreased well-being, concluding that micro aggressions do mediate the relationship of attitudes toward seeking help (Kim et al, 2016). These two studies relate to the current study as they represent an instance of Medical Mistrust within research and mental healthcare fields, therefore it could play a role in African-American or Asian American participants not seeking mental health treatment due to mistrust of the respective fields. In addition to Medical Mistrust, it is important to ask; what are the cultural values from a country, and do they have an impact on the stigma of mental health and help-seeking behaviors?

**Cultural Values**

In a 2011 study, researchers evaluated the relationship between mental illness stigma and cultural beliefs, values, and norms of a race or ethnic group. The study evaluated Americans of American Indian, Asian, African, Latino, Middle Eastern, and European descent. The literature showed that American Indians believe being is more important than doing therefore, they don't hold great value to wealth, education and status. It is believed that a person with mental illness is not very stigmatized but more so valued for focusing on introspection and inner self to become a better person, however there is a lack of empirical research to support this belief. In Asian cultures, there is very little distinction between the body and the mind, therefore it is common for Asians to display psychological symptoms somatically. Researchers suggested that people from Asian descent believe that mental illness is considered a punishment from God, supernatural forces, bad genes, or disrespecting their ancestors, which may contribute to the stigma of Asian cultures. (Abdullah & Brown, 2011). In addition, the research showed that public and self-stigma are due to cultural values, but more research is necessary to draw a precise conclusion. People of African descent generally hold values of collectivism, spirituality and role flexibility, therefore it is suggested that they may be stigmatized if they can't step up and take on the responsibilities considered valuable by their culture. Research showed that African Americans had higher public stigma, higher self-stigma, and more negative attitudes towards mental health treatment (Abdullah, & Brown, 2011).

Like those from Asian descent, those from Latino descent too share a common value of collectivism and interdependence. The research evaluated a comparison of two studies, one from 1997 that showed Latinos in the U.S perceived those with mental illness to be more dangerous. However, another study from 2007, showed Latinos perceived those with mental illness to be

less dangerous and had less desire for social distance from them. People from Middle Eastern descent generally hold a high value in concealing emotion, authority, and family honor. The researchers found that self-stigma may result in negative attitudes towards counseling because of the importance of family image (Abdullah & Brown, 2011). Lastly, Caucasians/Europeans were found to hold values of individualism, materialism, and competition. The data indicated that although the mental illness stigma is prevalent among Caucasians, they have lower rates in comparison to other racial/ethnic groups. In conclusion, it is shown that mental illness is a problem for all ethnic groups, and that there is no concrete evidence that shows if one cultural group stigmatizes more or less than another (Abdullah & Brown, 2011).

In a 2017 study, researchers evaluated the associations between cultural stressors, cultural values, and Latina/o college students' mental health. Participants were 198 Latina/o college students between the ages of 18 and 25, self-identified as Latina/o or Hispanic, and were able to complete the survey in English. Participants were given a demographics survey which measured descriptive statistics such as age, gender, race, country of birth, education level, religious affiliation immigrant status, and whether they were the first to attend college in their family (Corona et al., 2017).

Participants were then administered the Mexican American Cultural Values Scale (MCVS), which measured family support, family referents, respect, religiosity, and traditional gender roles and asked participants to respond, on a 5-Likert scale (1-Not at all, 5-Completely), to statements such as "Family provides a sense of security because they will always be there for you" and "It is important to follow the Word of God". Next participants completed The Brief Perceived Ethnic Discrimination Questionnaire-Community Version (Brief-PEDQ-CV), a 17 item questionnaire, which measures exclusion/rejection, stigmatization/devaluation,

discrimination at school/work, and threat/aggression. This questionnaire asked participants to respond, on a 5-Likert scale (1-Never, 5-Very often), to questions such as “How often have others hinted that you are dishonest or can’t be trusted?” and “How often have others made you feel like an outsider who doesn’t fit in because of your dress, speech, or other characteristics related to your ethnicity?”. Participants completed the Riverside Acculturative Stress Inventory (RASI), a 15 item questionnaire that assessed work, language skills, intercultural relations, discrimination, and cultural/ethnic make-up of the community. Lastly, participants completed the Depression, Anxiety, and Stress Scale (DASS) to assess depression, anxiety, and psychological stress. This 21 item questionnaire required participants to respond using a 4-point scale ranging from 0 “Did not apply to me at all” to 3 “Applied to me very much, or most of the time”.

The results showed that family support was the cultural factor most strongly associated with students’ depressive, anxiety, and psychological stress with students’ depressive, anxiety, and psychological stress symptoms (Corona et al., 2017). In addition to cultural values of a given culture, it is also important to ask; what influence does the media have on an individual’s perception of the mental health stigma, and whether or not they seek help from a professional?

**The Media**

Every single person has been influenced by the media. In a study, conducted in 2013, researchers analyzed the effects of new media messages about mass shootings on attitudes toward persons with serious mental illness and public support for gun control. In recent years, it seems as though mass shootings completed by people with mental illness received extensive news coverage. Some examples would include the Sandy hook Newtown, Connecticut shooting, the movie theatre Aurora, Colorado shooting, and the Virginia Tech shooting (McGinty et al, 2013). Using a national online sample, 1,797 participants were randomly separated into groups.

Each group had to read one of three news stories; 1) a mass shooting event by a person with serious mental illness who used a gun with a large-capacity magazine, 2) the same mass shooting event and a proposal for a gun restriction policy of persons with serious mental illness, and 3) the same mass shooting event and a proposal to ban large-capacity magazines. This method provided a way to assess attitudes as participants were asked questions such as "Would you be willing to have a person with serious mental illness start working closely with you on a job?" and "People with serious mental illness are, by far, more dangerous than the general population". The participants read their randomly assigned news story and then were asked to answer questions about their attitudes towards serious mental illness (McGinty et al, 2013).

The results showed that all three stories heightened negative attitudes toward persons with serious mental illness (McGinty et al, 2013). This is only one example of how the extremist views of the media, and how they present their information, readily villainizes people with a serious mental illness. This is relevant to the current study, because many people take what they know from the news or from a movie, believe it to be true, and generalize it. In actuality, one extreme case of mental illness does not represent the whole population. However, it should also be determined if important others in a person's life has an effect on the stigma they may carry about mental illness and help-seeking behaviors.

**Important Others**

It is necessary to understand the sociological theory, symbolic interaction stigma, which is the "important components of stigma that include imagining what others might think of a stigmatized status, anticipating what might transpire in an interaction with others, and rehearsing what one might do if something untoward occurs" (Link et al, 2015). In a study from 2015, researchers sought to explain how the reactions of others add to the burden of the mental illness

stigma, using the symbolic interaction stigma theory. A questionnaire was administered to participants about societal-level perceived discrimination, stigma consciousness, concern with staying in, and the anticipation of rejection, to evaluate whether these variables lead to internalization of stigma (Link et al, 2015). Participants were collected from three psychiatric hospitals in New York City between 2007-2009 based on their primary diagnosis of schizophrenia or other psychotic disorders. In reference to hospitalization, 37% were experiencing their first, as 32% were experiencing their second, and 31% had experienced a third to sixth hospitalization (Link et al, 2015). Surveys were administrated to measure participants' experience of rejection due to psychiatric hospitalization, and societal level of discrimination. Other variables such as staying in/rejection sensitivity, anticipation of rejection, internalized stigma, and withdrawal, were also evaluated (Link et al, 2015).

The results showed that the "anticipation of rejection predicted withdrawal, stigma consciousness predicted self-esteem, and concern with staying in predicted isolation from relatives". In addition, the researchers found that "symbolic interaction forms of stigma predicted the internalization of stigma with anticipation of rejection playing the largest role" (Link et al, 2015). In conclusion, this article shows that how people with a mental illness feel when viewed by others has an impact of their internalization of stigma. In translation, if someone you see as an important person in your life has a negative perception of mental health and the stigma, it could play a role in how you see yourself with the mental illness. However, the last variable examined may change how someone looks at mental illness. The question ponders: does the fact that a person has a family member, or close friend who has been diagnosed with a mental illness, have an impact on how they perceive the mental health stigma and help-seeking behaviors?

**Personal Relationships**

In a study from 2010, researchers sought to discover if the relationship of personal contact with someone hospitalized for mental illness would have an impact on the multiple aspects of stigma. Participants consisted of 911 people who were 18 and older, living in households with telephones in the United States between 2002 and 2003. Participants were randomly assigned to one of the two vignettes, in which described either a physical symptomology or a mental symptomology. Next, participants are given a mental illness vignette, either schizophrenia or major depressive disorder. Measures such as contact, blame, anger, sympathy, perceived persistence, perceived seriousness, social distance, and reproductive restriction were evaluated using other surveys and questionnaires (Boyd et al, 2010). Results found that "more contact was associated with less blame for the mental illness toward the vignette character, less anger toward the character, and less social distance from the character, in both causal and intimate aspects", and that "those with greater contact judged the character's problem to be more serious" (Boyd et al, 2010). Overall, the results generally showed that people who had contact with someone who had been hospitalized before were less likely to hold such a criticizing stigma towards the mentally ill.

In a 2015 study, researchers Jacob B. Priest and Sarah B. Woods, examined the role of close relationships in the mental and physical health of Latino Americans. Researchers hypothesized that the connection between negative family emotional climate and disease activity would be indirect, fully mediated by bio behavioral reactivity (Priest & Woods, 2015). Participants included 2,554 Latino and Asian adults who were collected from the National Latino and Asian American Study (NLAAS). All materials were translated accordingly. Participants were measured based on Negative Family Emotional Climate, a 5 item questionnaire, which

references negative attributes of their families such as arguing and feeling isolated. Another measure used, the Romantic Partner Emotional Climate, a 4 item questionnaire, which references negative attributes of the relationship with their romantic partner such as letting their significant other down or getting on their nerves. Using items from the Composite Interactional Diagnostic Interview (CIDI), bio behavioral reactivity or anxiety and depression, was assessed. Lastly, disease activity was assessed by asking participants questions such as "Have you ever had one of the seven chronic conditions: arthritis, back/neck problems, seasonal allegories, any other type of chronic pain, stroke, and/or heart disease?" and "How many prescriptions had they taken in the past 7 days?"

Researchers found that the association between family emotional climate and disease activity was not fully mediated for U.S. born Latinos. "When testing the BBFM with adult Latino American family members, U.S. born and foreign born Latinos were significantly different" (Priest & Woods, 2015). It was not the pathway between family emotional climate and disease activity that was the difference. In addition, a significant direct pathway between romantic partner emotional climate and disease activity was found (Priest & Woods, 2015). These are relevant to the current study because it is possible that the students that are to participate in the current study may know someone who is mentally ill and it could impact their perception of mental illness and help-seeking behaviors.

**The Current Study**

The following definitions were operationalized using the Online Oxford dictionary. Mental health is a person's condition with regard to their psychological and emotional well-being. In addition, stigma is a mark of disgrace associated with a particular circumstance, quality, or person. Therefore, for the current study mental health stigma was defined as a mark of

disgrace associated with a person's condition in regard to their psychological and emotional well-being.

Three mediator variables were evaluated during this study including medical mistrust, cultural values, and the media. Medical mistrust is an untrusting attitude due to historical oppression based on race/ethnicity. Cultural values were defined as the ideas, customs, and social behavior of a society that are held to a high importance. The media were the main means of mass communication (broadcasting, publishing, and the Internet) regarded collectively. This is the definition that was used for this study, and will specifically look at the media collectively through print, television, movies, video games, and social media.

Two moderator variables were evaluated during this study including important others and personal relationships. Important others were the people the person who had been diagnosed as mentally ill, sees as a role model or important figure in their lives. Therefore, if that important figure had a negative perception of mental illness the person with the illness may feel judged or rejected due to internalization of the mental health stigma. Personal relationships were whether or not the person had a personal contact, like a family member or close friend, who had been diagnosed with a mental illness.

Medical mistrust, cultural values, and the media were included as mediator variables because cross-cultural/countries may have an effect on the mental illness stigma, however it may be mediated by the above variables. In addition, personal relationships and important others were included as moderator variables as they could influence the independent variable (persons of cross-cultural/countries) to exert its effects on the dependent variables (mental illness stigma, help-seeking behavior).

The current study sought to understand how American students perceive mental illness, and if International students perceive mental illness differently. This was a comparative study that strived to integrate variables such as medical mistrust, cultural values, the media, the perception of important others, and personal relationships, with a person who has a mental illness (See Figure 1). This study was needed because the mental health stigma is still an ongoing problem in the United States, and is likely still an ongoing problem in other countries as well. This study hoped to bring awareness to students of their biases towards persons of mental illness. It was hypothesized that American students would be significantly less likely to stigmatize mental illness, and more likely to seek professional help than International students. In addition, it was hypothesized that both American and International students' perception of mental illness would be significantly negatively impacted by the media and positively impacted by having a personal relationship with someone who has been diagnosed with a mental illness.

## Method

### Participants

Participants were collected through an online survey distributed to the students of Tennessee Technological University and distributed to online social media platforms such as Facebook and Reddit. Students received the link to the online survey from professors who generously sent emails to the students in their classes, possibly for extra credit, or from a social media post. In addition, the survey was posted in Tech Times and flyers were distributed throughout campus with a link and QR code to the online survey. Each participant was provided with an informed consent document to ensure all responses were completely confidential. Generally, American students were collected from the general population of campus and International students were collected from the Global Learning Village. In addition, students

were collected from online social media platforms. This sample was chosen due to the variability of their backgrounds.

Researchers collected 399 students, however, 51 participants were deleted due to missing values. Of these, 348 completed the online survey consisting of stigma related questionnaires. Of those 348 students, 332 were American students and 16 were International students. In terms of age, participants were required to be 18 years or older (*M = 20.18, SD= 6.*26). In terms of gender, 153 students self-identified as male (44%), 187 students self-identified as female (53.7%), 4 students self-identified as other (1.1%), and 4 students preferred not to respond (1.1%). In terms of highest completed level of education, 4.9% completed high school, 45.4% were college freshmen, 20.7% were college sophomores, 17.2% were college juniors, 8.6% were college seniors, 2.6% held a bachelor's degree, and 0.6% held a Master's degree.

No participants under the age of eighteen were allowed to participate as a minor may not legally give informed consent. In addition, all participants were required to be able to read and understand the English language. Participants completed the survey online on their own time. In addition, participants may have been eligible to receive extra credit, if applicable to the professor, for completing the survey.

**Materials**

Participants completed a series of surveys to assess their attitudes towards mental illness, their attitudes towards seeking mental health treatment, and other variables such as medical mistrust, cultural values, the media, personal relationships and important others. In addition, a model of these variables were provided (See Figure 1). Participants were provided with an Informed Consent document to ensure confidentiality and maintain anonymity (Appendix A). The Beliefs towards Mental Illness Questionnaire (BMI) is a 21-item self-report measure of

negative stereotypical views of mental illness (*M* = 2.67, *SD* = 0.56, Appendix B). This questionnaire asked participants to respond on a 5-Likert scale (1-Completely Disagree, 5-Completely Agree) to questions such as "A mentally ill person is more likely to harm others than a normal person" and "The behavior of people who have psychological disorders are unpredictable".

Next, Participants completed the Perceived Stigma Questionnaire (PSQ) which measures the perceived stigma of participants on four scales; devaluation-discrimination, secrecy, withdrawal and education (*M* = 3.05, *SD* = 0.31, Appendix C) using a 6-Likert scale (1-Strongly Disagree, 6- Strongly Agree). Participants responded to questions such as "I would willingly accept an individual who receives mental health services as a close friend" and "I would not hire an individual who receives mental health services to take care of my children even if he/she has been well for some time". The Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS) is a 25 item scale that is used to measure help seeking behaviors based psychological openness, help-seeking propensity, and indifference to stigma (*M* =2.95, *SD* = 0.37, Appendix D). This questionnaire uses as a 5-Likert scale (1-Strongly Disagree, 5-Strongly Agee) and participants responded to questions such as "Important people in my life would think less of me if they were to find out that I was experiencing psychological problems", which assesses the important others variable, and "There is something admirable in the attitude of people who are willing to cope with their conflicts and fears without resorting to professional help".

Medical mistrust was measured using the Trust in Physician Scale (*M* = 3.36, *SD* = 0.44, Appendix E) which measures the participants trust in physicians and counselors within the medical and mental health field. This is an 11-item scale that participants respond on a 5-Likert scale (1-Completely Disagree, 5-Completely Agree) to statements such as "I doubt my

doctor/counselor really cares about me as a person" and "I sometimes worry that my doctor/counselor may not keep the information we discuss totally private". In addition, a figure of the Schwartz Value Theory was provided (See Figure 2). A shortened version of The Schwartz Value Survey (Appendix F) was used to assess cultural values on a 9-Likert scale (0-oppossed to my principles, 8-of supreme importance to my principles). This survey is a 10-item instrument that participants rate the importance of each value item "as a guiding principle in my life", those principles which include power ($M$ = 3.81, $SD$ = 1.84), achievement ($M$ = 6.07, $SD$ = 1.77), hedonism ($M$ = 4.92, $SD$ = 2.16), stimulation ($M$ = 4.84, $SD$ = 2.06), self-direction ($M$ = 6.15, $SD$ = 1.79), universalism ($M$ =5.00, $SD$ = 2.27), benevolence ($M$ = 6.75, $SD$ = 1.63), tradition ($M$ = 5.10, $SD$ = 2.33), conformity, and security.

Next, the Demographics survey (Appendix G) measured the age, gender, level of education, and race/ethnicity. In addition, the media was evaluated in the survey using the question "How do you think the media portrays individuals with mental illness issues?". The personal relationships variable was also evaluated in the Demographics survey using the question "Do you have a personal relationship with someone who has been diagnosed with a mental illness? Please specify. (I.e. friend, cousin, aunt, coworker)". In addition, the students anonymously identified if they were an American student or International student, and specified their state and country. Lastly, after the completion of all surveys, participants were given a debriefing form (Appendix H) about the study.

**Procedure**

Using the online Qualtrics Research Platform, participants opened the link and completed the surveys. All participants were at least 18 years or older, and thoroughly read and electronically signed the Informed Consent document to ensure complete confidentiality and

agreeance to participate in this study. Next, participants completed the Beliefs towards Mental Illness Questionnaire (BMI), Perceived Stigma Questionnaire (PSQ), and The Inventory of Attitudes Toward Seeking Mental Health Services (ATSMHS) surveys. From their personal opinions, participants completed the Physicians Trust Scale and the Short Schwartz Value Survey. Participants completed the demographics survey and if they wished to receive extra credit for participation from professors, they completed an extra credit form. Once participants completed all surveys, they received a debriefing form that described the study in detail.

## Results

The results were analyzed using a multiple regressions analysis to determine if American students perceive mental illness differently than International students. The mediator variables of medical mistrust, the media, and cultural values and the moderator variables of personal relationships and important others were assessed to evaluate their roles in the perceived mental illness stigma and one's willingness to seek help. Separate multiple regression analysis were performed on the BMI and PSQ, with personal relationship, respondents' gender, and ATSMHS, and SSVS as predictors using the backward elimination method. PSQ scores resulted in a best prediction equation PSQ=-.068 (Personal Relationship) + 3.38. Regression analysis of BMI scores yielded a best prediction equation of BMI = 4.27(Personal Relationship)-2.07(Gender) + .05(Power) + .03(Achievement) - .05(Self-Direction) + 1.67. This results means that those who *do not* personally know someone with a mental illness, males, those who place more importance on the values of Power and Achievement, and place less importance on the value of Self-Direction report significantly greater stigma towards those diagnosed with mental illnesses.

## Discussion

The purpose of the current study was to understand the perception of mental illness, from a cross-cultural, comparative perspective with a convenience sample of undergraduate college students. Participants completed a survey examining their view on mental illness, while exploring associated variables such as medical mistrust, cultural values, the media, the perception of important others, and personal relationships. Two of the researchers' hypotheses were found to be inconclusive, however, the data suggested support for the other two hypotheses. the results did support the hypothesis that both American and International students' perception of mental illness would be significantly negatively impacted by the media and positively impacted by having a personal relationship with someone who has been diagnosed with a mental illness.

In the current study, two different questionnaires were used to measure the mental illness stigma dependent variable: The Beliefs Toward Mental Illness questionnaire (BMI) and the Perceived Stigma Questionnaire (PSQ). Of all questionnaires, some questions were reverse scored for acquiescence respondents. Analysis of the BMI questionnaire found that, on average, participants somewhat disagreed ($M = 2.67$) to the statements on the BMI questionnaire. Analysis of the PSQ questionnaire found that participants somewhat disagreed ($M = 3.05$) to the statements on the PSQ. These two measures counter balanced one another. The Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS) was used to measure the dependent variable of willingness to seek mental health services. Analysis of the IASMHS questionnaire found that, on average, participants somewhat disagreed (M =2.95) with the statements. Medical mistrust was measured using the Trust in Physician Scale (TPS) which measures the participants trust in physicians and counselors within the medical and mental health

field. Analysis of the TPS questionnaire found that, on average participants neither disagreed nor agreed ($M$ = 3.36) with the statements, which led to an inconclusive finding.

With the Short Schwartz Value Survey (SSVS), participants were asked to indicate on an 8-point scale, eight values relate to their life as opposed to their principles, important to their principles, and as a life-guiding principle. Three of the eight values from the Short Schwartz Value Survey (SSVS), Power ($M$ = 3.81), Achievement ($M$ = 6.07) and Self-Direction ($M$ = 6.15) resulted in significant data. Power was defined as social power, authority, or wealth. Achievement was defined as success, capability, ambition, and influence on people and events. Self-Direction was defined as creativity, freedom, curiosity, independence, and choosing one's own goals. The best prediction equation for BMI suggested that those who *do not* personally know someone with a mental illness, males, those who place more importance on the values of Power and Achievement, and place less importance on the value of Self-Direction report significantly greater stigma towards those diagnosed with mental illnesses.

Within the demographics survey participants were asked, "How do you think the media portrays individuals with mental illness issues?" participants responded somewhat negatively ($M = 2.06$, $SD = 0.79$). This result supports the hypothesis that both American and International students believed that the media has a significant negative impact on the perception of mental illness. In addition, when participants were asked "Do you have a personal relationship with someone who has been diagnosed with a mental illness?" 59.8% of participants responded yes and 40.2% of participants responded no. These preliminary findings confirm the negative influence the media can have on the mental health stigma and the importance of personal contact with people who have a mental health diagnosis for reducing stigma toward mental illness. Previous literature has found related findings.

Researchers McGinty and colleagues randomly assigned participants to one of three vignettes: 1) a mass shooting event by a person with serious mental illness who used a gun with a large-capacity magazine, 2) the same mass shooting event and a proposal for a gun restriction policy of persons with serious mental illness, and 3) the same mass shooting event and a proposal to ban large-capacity magazines." The participants read their news story and then were asked to answer questions about their attitudes towards serious mental illness. The results indicated that all three stories heightened negative attitudes toward persons with serious mental illness (McGinty et al, 2013). In addition, in 2010, Boyd and colleagues examined the relationship of personal contact with someone hospitalized for mental illness would have an impact on the multiple aspects of stigma. Participants were randomly assigned to one of two vignettes, in which described either a physical symptomology or a mental symptomology. Next, participants are given a mental illness vignette, either schizophrenia or major depressive disorder. Overall, the results suggested that people who had contact with someone who had been hospitalized before were less likely to hold such a criticizing stigma towards the mentally ill. These results support two of the four hypotheses from the current study.

Although significant results were found, this study did encounter some limitations. One of the main limitations of this study is the lack of International student participants. The purpose of this study was to perform a cross-cultural comparison, and this could not empirically be done, as only 16 International students were collected. The central limit theorem suggests that if at least 30 participants are collected, they will create an approximately normal distribution, or bell curve. The data did not meet the criteria for the central limit theorem, therefore, the hypothesis that American students would be significantly less likely to stigmatize mental illness, and more likely to seek professional help than International students, was not able to be addressed and

found to be inconclusive. In addition, although convenience sampling is beneficial when addressing one type of population, like college students, it may not correctly represent population of other ages and attitudes/stigmas toward mental illness. Also, due to researcher error, two of the ten cultural values from the Short Schwartz Value Survey (SSVS), Conformity and Security, were omitted by accident. This limits the research, as both conformity and security would have been interesting values to consider in this study. Furthermore, the online survey platform may lead to inaccurate results due to uncontrollable factors such as fatigue effects and environmental surroundings.

However, future research is a necessity, specifically with participants from various cultural backgrounds, to determine the similarities and differences between American and International participant perceptions on the mental health stigma and help-seeking. Researchers may want to update the literature on the impact of the media on the mental health stigma by investigating social media such as Instagram and Facebook. In addition, researchers should examine the effect of personal relationship using a longitudinal design to allow for causal analyses and a larger sample so that the relationship between stigma and the type and extent of personal relationship can be analyzed more thoroughly.

Overall, researchers anticipated to learn more about how both American and International students perceive mental health stigma, while exploring how various variables impact the mental health stigma and help seeking behaviors. It was hypothesized that American students would be significantly less likely to stigmatize mental illness, and more likely to seek professional help than International students. The results were inconclusive for this hypothesis due to lack of International student participation. In addition, as hypothesized, the results found support that both American and International students' perception of mental illness would be significantly

negatively impacted by the media and positively impacted by having a personal relationship with someone who has been diagnosed with a mental illness. Based on the BMI best prediction equation, participants that held a personal relationship with someone with a mental illness, held significantly less stigma toward those diagnosed with a mental illness. Moreover, when participants were asked "How do you think the media portrays individuals with mental illness issues?" participants responded somewhat negatively (*M = 2.06, SD = 0.79)*. The current study found that those who *do not* personally know someone with a mental illness, males, those who place more importance on the values of Power and Achievement, and place less importance on the value of Self-Direction report significantly greater stigma towards those diagnosed with mental illnesses. More importantly, these findings point to the significant role that cultural values play in stigma toward people with mental illness suggesting that cultural transmitters such as popular media, enculturation processes, and cultural differences must be examined in future research.

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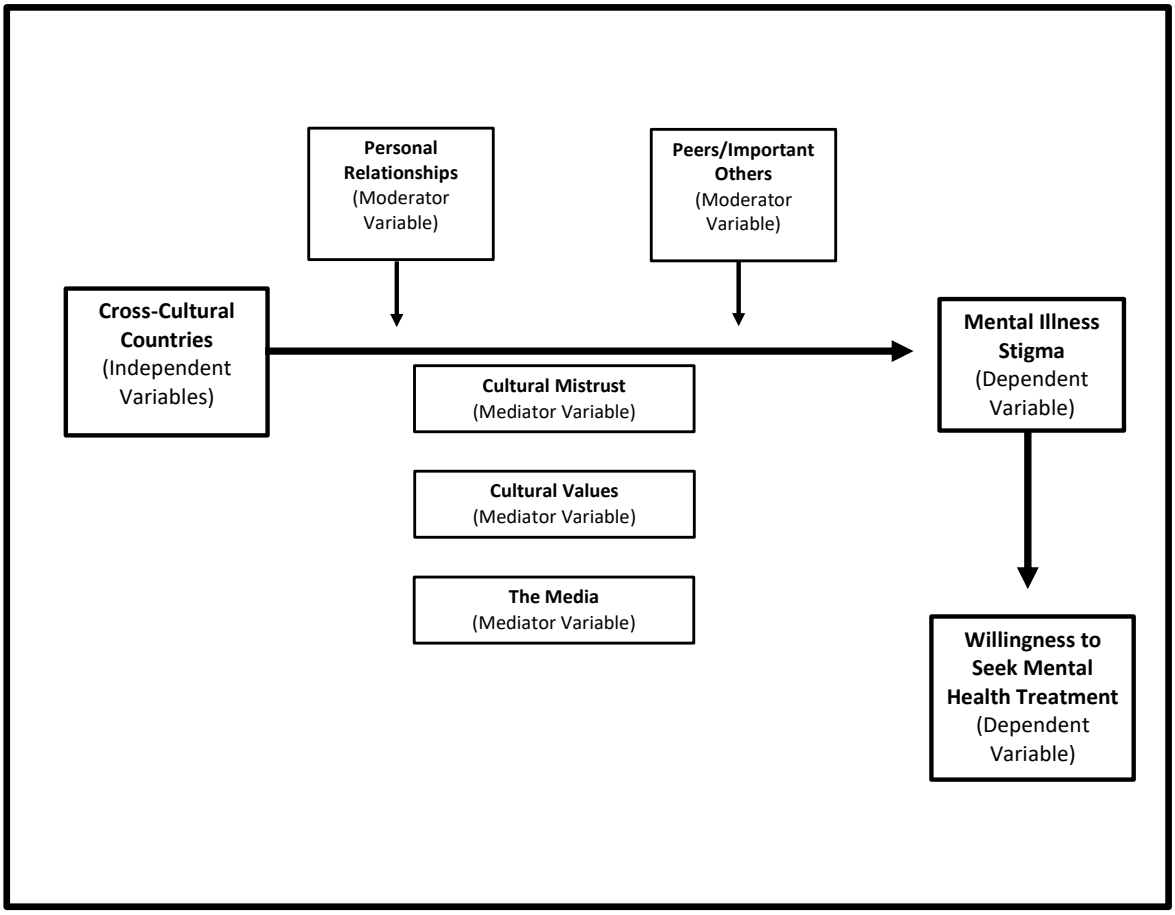


*Figure 1.* The Relationship of Variables which illustrates the independent, dependent, mediator and moderator variables.

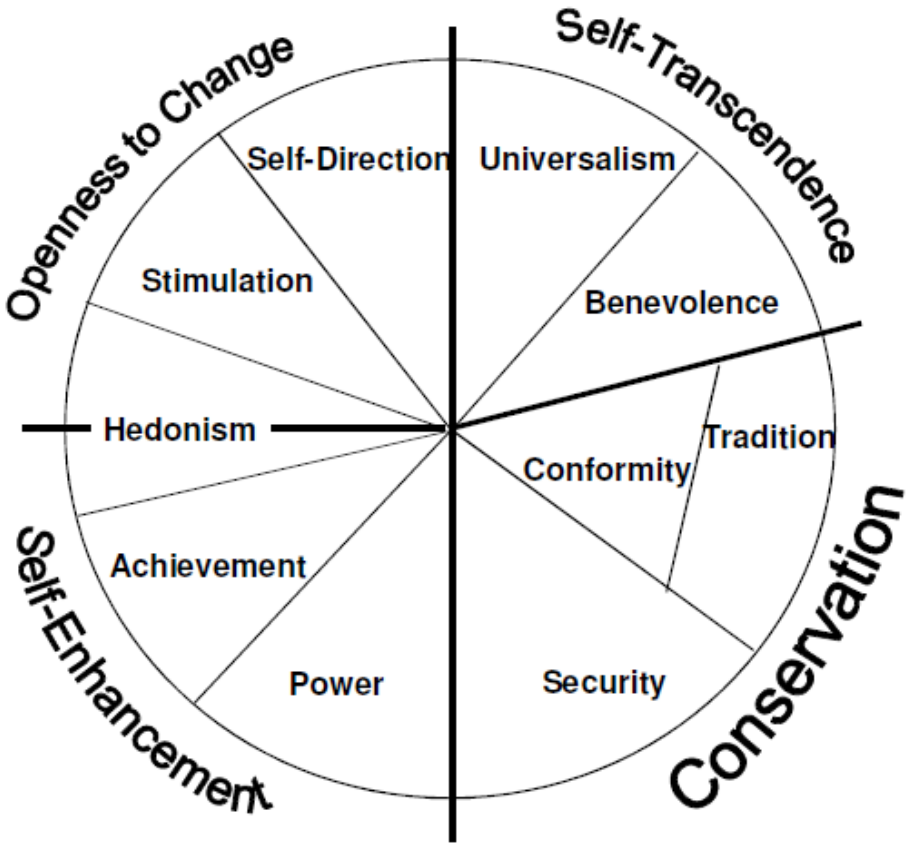


*Figure 2*. The Schwartz Theory of Basic Values is a theoretical model of relations among ten motivational types of value. Adapted from Schwartz, S. (2012). An Overview of the Schwartz Theory of Basic Values. *Online Readings in Psychology and Culture, 2*(1), Online Readings in Psychology and Culture, 12/01/2012, Vol.2 (1).

# Appendix A

## Informed Consent Form

Welcome! My name is Chassidy Overstreet and I am an undergraduate psychology student at Tennessee Technological University. I invite you to participate in my senior thesis research study which seeks to evaluate how American students perceive mental illness in comparison to international students. If you are under 18 years of age and cannot read English, please do not complete this form. Involvement in the study is voluntary, so you may choose to participate or not. You will not be subject to any negative consequences for not participating, terminating your involvement, or not completing the questionnaire. This study will take approximately 15 minutes as you are asked to honestly complete several brief questionnaires. By consenting to participate, you consent to have your anonymous responses used for scientific research, possible presentation and/or publication. Should you decide to participate in this research study, you will be asked to sign this consent form once all your questions have been answered to your satisfaction. If you have any other questions, please contact me at croverstre42@students.tntech.edu.

I have read and been informed about this study.

- ○ I am 18 years of age and consent to participate.
- ○ I am not 18 years of age and/or I do not consent to participate.

## Appendix B

Beliefs towards Mental Illness Questionnaire (BMI)

Please indicate the extent to which you agree or disagree based on your personal opinions by using the following 5-Likert scale: 1 – Completely Disagree, 2 – Somewhat Disagree, 3 – Neither Disagree nor Agree, 4 – Somewhat Agree, and 5 - Completely Agree.

1. A mentally ill person is more likely to harm others than a normal person.

   1 2 3 4 5

2. Mental disorders would require a much longer period of time to be cured than would other general diseases.

   1 2 3 4 5

3. It may be a good idea to stay away from people who have a psychological disorder because their behavior is dangerous.

   1 2 3 4 5

4. The term ‘psychological disorder’ makes me feel embarrassed.

   1 2 3 4 5

5. A person with a psychological disorder should have a job with only minor responsibilities.

   1 2 3 4 5

6. Mentally ill people are more likely to be criminals.

   1 2 3 4 5

7. A psychological disorder is recurrent.

   1 2 3 4 5

8. I am afraid of what my boss, friends and others would think if I were diagnosed as having a psychological disorder.

1 2 3 4 5

8. Individuals diagnosed as mentally ill suffer from its symptoms throughout their life.

1 2 3 4 5

9. People who have once received psychological treatment are likely to need further treatment in the future.

1 2 3 4 5

10. It might be difficult for mentally ill people to follow social rules such as being punctual or keeping promises.

1 2 3 4 5

11. I would be embarrassed if people knew that I dated a person who once received psychological treatment.

1 2 3 4 5

12. I am afraid of people who are suffering from a psychological disorder because they may harm me.

1 2 3 4 5

13. A person with a psychological disorder is less likely to function well as a parent.

1 2 3 4 5

14. I would be embarrassed if a person in my family became mentally ill.

1 2 3 4 5

15. I believe that a psychological disorder can never be completely cured.

1 2 3 4 5

16. Mentally ill people are unlikely to be able to live by themselves because they are unable to assume responsibilities.

    1 2 3 4 5

17. Most people would not knowingly be friends with a mentally ill person.

    1 2 3 4 5

18. The behavior of people who have psychological disorders are unpredictable.

    1 2 3 4 5

19. A psychological disorder is unlikely to be cured regardless of treatment.

    1 2 3 4 5

20. I would not trust the work of a mentally ill person assigned to my work team.

    1 2 3 4 5

## Appendix C

The Perceived Stigma Questionnaire (PSQ)

Please fill in the blank with the number that best reflects your opinion. Scores range from 1 indicating Strongly Disagree to 6 indicating Strongly Agree.

1. I would willingly accept an individual who receives mental health services as a close friend.

   1 2 3 4 5 6

2. I would believe that a person who has been in a mental hospital is just as intelligent as the average person.

   1 2 3 4 5 6

3. I believe that an individual who receives mental health services is just as trustworthy as the average person.

   1 2 3 4 5 6

4. I would accept a fully recovered individual who receives mental health services as a teacher of young children in a public school.

   1 2 3 4 5 6

5. I believe that entering a mental hospital is a sign of personal failure.

   1 2 3 4 5 6

6. I would not hire an individual who receives mental health services to take care of

   my children even if he/she has been well for some time.

   1 2 3 4 5 6

7. I think less of a person who has been in a mental hospital.

   1 2 3 4 5 6

8. I would hire an individual who receives mental health services if he or she is

   qualified for the job.

   1 2 3 4 5 6

9. I would pass over the application of an individual who receives mental health services in favor of another applicant.

   1 2 3 4 5 6

10. Most people in my community would treat a person who receives mental health services just as they would treat anyone else.

    1 2 3 4 5 6

11. Most young people would be reluctant to date someone who has been hospitalized for a serious mental disorder.

    1 2 3 4 5 6

12. Once I know a person is in a mental hospital, I will take his or her opinion less seriously.

    1 2 3 4 5 6

## Appendix D

Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS)

Please honestly indicate your willingness to seek mental health services if it was needed. Scores range from 1 indicating Strongly Disagree to 5 indicating Strongly Agree.

1. There are certain problems which should not be discussed outside of one's immediate family.

   1 2 3 4 5

2. I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems.

   1 2 3 4 5

3. I would not want my significant other (spouse, partner, etc.) to know if I were suffering from psychological problems.

   1 2 3 4 5

4. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.

   1 2 3 4 5

5. If good friends asked my advice about a psychological problem, I might recommend that they see a professional.

   1 2 3 4 5

6. Having been mentally ill carries with it a burden of shame.

   1 2 3 4 5

7. It is probably best not to know *everything* about oneself.

   1 2 3 4 5

8. If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief in psychotherapy.

   1 2 3 4 5

9. People should work out their own problems; getting professional help should be a last resort.

1 2 3 4 5

10. If I were to experience psychological problems, I could get professional help if I wanted to.

1 2 3 4 5

11. Important people in my life would think less of me if they were to find out that I was experiencing psychological problems.

1 2 3 4 5

12. Psychological problems, like many things, tend to work out by themselves.

1 2 3 4 5

13. It would be relatively easy for me to find the time to see a professional for psychological problems.

1 2 3 4 5

14. There are experiences in my life I would not discuss with anyone.

1 2 3 4 5

15. I would want to get professional help if I were worried or upset for a long period of time.

1 2 3 4 5

16. I would be uncomfortable seeking professional help for psychological problems because people in my social or business circles might find out about it.

1 2 3 4 5

17. Having been diagnosed with a mental disorder is a blot on a person's life.

1 2 3 4 5

18. There is something admirable in the attitude of people who are willing to cope with their conflicts and fears *without* resorting to professional help.

1 2 3 4 5

19. If I believed I were having a mental breakdown; my first inclination would be to get professional attention.

1 2 3 4 5

20. I would feel uneasy going to a professional because of what some people would think.

1 2 3 4 5

21. People with strong characters can get over psychological problems by themselves and would have little need for professional help.

1 2 3 4 5

22. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.

1 2 3 4 5

23. Had I received treatment for psychological problems, I would not feel that it ought to be "covered up."

1 2 3 4 5

24. I would be embarrassed if my neighbor saw me going into the office of a professional who deals with psychological problems.

1 2 3 4 5

## Appendix E

Trust in Physicians Scale

Please indicate the extent to which you agree or disagree based on your personal experiences with your doctor/counselor using the following 5-Likert scale: 1 – Completely Disagree, 2 – Somewhat Disagree, 3 – Neither Disagree nor Agree, 4 – Somewhat Agree, and 5 - Completely Agree.

1. I doubt my doctor/counselor really cares about me as a person.

   1 2 3 4 5

2. My doctor/counselor is usually considerate of my needs and puts them first.

   1 2 3 4 5

3. I trust my doctor/counselor so much I always try to follow his/her advice.

   1 2 3 4 5

4. If my doctor/counselor tells me something is so, then it must be true.

   1 2 3 4 5

5. I sometimes distrust my doctor's/counselor's opinion and would like a second one.

   1 2 3 4 5

6. I trust my doctor's/counselor's judgements about my medical/mental health care.

   1 2 3 4 5

7. I feel my doctor/counselor does not do everything he/she should for my medical/mental health care.

   1 2 3 4 5

8. I trust my doctor/counselor to put my medical/mental health needs above all other considerations when treating my medical problems.

   1 2 3 4 5

9. My doctor/counselor is a real expert in taking care of medical/mental health problems like mine.

   1 2 3 4 5

10. I trust my doctor/counselor to tell me if a mistake was made about my treatment.

    1 2 3 4 5

11. I sometimes worry that my doctor/counselor may not keep the information we discuss totally private.

    1 2 3 4 5

## Appendix F

The Short Schwartz Value Survey

Please, rate the importance of the following values as a life-guiding principle for you. Use the 8-point scale in which 0 indicates that the value is opposed to your principles, 1 indicates that the values is not important for you, 4 indicates that the values is important, and 8 indicates that the value is of supreme importance for you.

| | Opposed to my principles | Not important | | | Important | | | | Of supreme importance |
|---|---|---|---|---|---|---|---|---|---|
| 1. POWER (social power, authority, wealth) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 2. ACHIEVEMENT (success, capability, ambition, influence on people and events) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 3. HEDONISM (gratification of desires, enjoyment in life, self-indulgence) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 4. STIMULATION (daring, a varied and challenging life, an exciting life) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 5. SELF-DIRECTION (creativity, freedom, curiosity, independence, choosing one's own goals) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 6. UNIVERSALISM (broad-mindedness, beauty of nature and arts, social justice, a world at peace, equality, wisdom, unity with nature, environmental protection) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 7. BENEVOLENCE (helpfulness, honesty, forgiveness, loyalty, responsibility) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 8. TRADITION (respect for tradition, humbleness, accepting | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| one's portion in life, devotion, modesty) | | | | | | | | | |
| 9. CONFORMITY (obedience, honouring parents and elders, self-discipline, politeness) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 10. SECURITY (national security, family security, social order, cleanliness, reciprocation of favours) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |

## Appendix G

Demographics Survey

1. Which is your student status? (Please specify state, and country)
    - American student: _____
    - International student: _____
2. Please type in your age: _____
3. What is your gender?
    - Male
    - Female
4. What is your highest completed level of education?
    - Some College: Please indicate your year here (i.e. freshman) _____
    - Bachelor's Degree
    - Master's Degree
    - PhD Degree
5. What is your race/ethnicity?
    - Caucasian
    - African-American
    - Asian American
    - Hispanic/Latino
    - Other: fill in the blank _____

6. How do you think the media portrays individuals with mental illness issues?
    - Very positively
    - Somewhat positively
    - Neither positively/nor negatively
    - Somewhat negatively
    - Very negatively
7. Do you have a personal relationship with someone who has been diagnosed with a mental illness? Please specify. (i.e. friend, cousin, aunt, coworker)
    - Yes; Specifically: _____
    - No
8. Will you receive extra credit for participating in this survey?
    - No
    - If yes, please specify the class number, section number, and professor's name.

# Appendix H

## Debriefing Form

Thank you for participating in this study! This form is to help you understand how and why we conducted this study. The purpose of this study was to determine how American students perceive mental illness in comparison to International students. It is hypothesized that American students will be significantly less likely to stigmatize mental illness, and more likely to seek professional help than International students.

As you know, your participation in this study is completely voluntary. If you wish to withdraw from this study after reading this form, all your recorded responses from participating will be destroyed and you will not be penalized for withdrawing. We ask that you do not discuss the nature or procedures of the experiment with anyone else who might be a future participant of this experiment.

If you have any questions, feel free to contact the experimenter, Chassidy Overstreet at croverstre42@students.tntech.edu.

Thank you for your participation!