The Role of Attributions in Mental Health Stigma

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The stigma surrounding mental health is a big problem in society today and serves to limit those struggling with mental illness in terms of jobs, housing, and relationships. One possible source of this stigma are the attributions individuals have regarding those with mental illnesses – in other words, people’s reasoning about why individuals have mental illnesses. This study will empirically investigate how these attributions serve to either diminish or exacerbate stigma. I will specifically investigate attributions regarding nature versus nurture (biology vs. experiences) to see which attribution, if either, serves to increase or lower stigma surrounding different mental illnesses. First, I review the literature surrounding mental health stigma and what is currently known about the role that nature and nurture attributions play. Then the empirical section of this study will begin, where 82 participants will take part in a survey designed to assess the different facets of stigmatization I plan on investigating. I hypothesize that increased endorsement of biological explanations will predict reduced stigma, in line with most research on this topic. More importantly, the present study will also examine how experiential attributions (i.e., those citing trauma, experiences, or “nurture”) for mental illness impact stigma – a question which little research has explored. I hypothesize that experiential explanations will also reduce stigma by reducing perceptions of controllability or blameworthiness, though I predict this will be weaker than the effect of biological explanations. Finally, I also hypothesize that certain illnesses will be more stigmatized than others, so the effects of different explanations might differ across different illnesses.
Mental Health Stigma

What is stigma? In ancient Greece, a “stigma” was a brand that was used to burn the skin of slaves or criminals to mark them as someone lesser or dangerous (Rössler, 2016). Although today the word stigma doesn’t directly refer to a literal brand, the term still stands true to what it means and feels like to be stigmatized – viewed as lesser or dangerous.

One important and under-examined source of stigma is stigma around poor mental health. This stigma is profoundly prevalent across cultures as well as throughout history. One paper reported that poor mental health is stigmatized across 27 countries (Rössler, 2016). Pescosolido and colleagues (2012) examined cross-cultural trends in mental health stigma using data from sixteen different countries. They found evidence of mental health stigma across the board, and there were similar patterns across cultures: Stigma was especially high regarding self-harm and suicide, people especially stigmatized those with mental illness in authoritative positions, and people were nervous to interact with these individuals over the fear of violence or a potentially awkward situation (Pescosolido et al., 2012). Around the world, it seems that most people are somewhat afraid of the mentally impaired and avoid contact and interaction with them, as well as being uncomfortable with them being in any sort of powerful position. This ambivalence towards contact with the mentally ill shows not only fear, but distrust. Distrust seems to be another common theme in mental health stigmas, and it seems to be thought that those suffering from mental illness are erratic and untrustworthy.

In addition to being stigmatized across cultures, mental health has also been stigmatized across hundreds of years of history, according to a recent paper by psychiatrist Wulf Rössler (2016). The review reports that, for much of history, those with mental disabilities were treated like criminals – either put in prison, tortured, or killed. In the Middle Ages, those with mental
illness were thought to be possessed by the devil and they were burnt at the stake, or put into madhouses where they were chained to the walls or their beds. During the Enlightenment, institutions were set up to support those struggling with mental illness, but these institutions functioned like jails and patients were largely mistreated by the staff. During the Nazi regime in Germany, hundreds of thousands of mentally impaired were either incinerated or sterilized. In sum, quite obviously, the treatment of the mentally ill in our society has historically been inhumane and torturous.

Mental health stigma continues to be a major problem today. Studies have found that citizens are less likely to hire persons who are labeled mentally ill (Farina & Felner, 1973; Bordieri & Drehmer 1986; Link, 1987) and are less likely to lease them apartments (Page, 1977, 1983; Alisky & Iczkowski, 1990). Although the information collected through that study spanned from the 1970s to the late 1980s, these issues still exist for those who struggle with mental illness. These individuals aren’t given the same living and employment opportunities as the rest of the population (Farina & Felner, 1973; Bordieri & Drehmer 1986; Link, 1987), (Page, 1977, 1983; Alisky & Iczkowski, 1990). If stigmatization could be lowered for these individuals, I think that those suffering from mental illness would be allowed more opportunities and a chance at leading a more “normal life” compared to what they experienced before.

It is clear that there needs to be ways in which we can reduce the stigma surrounding mental illness, especially for the younger generations. Members of older generations may be holding onto ideas about mental illness that are a product of their time. Members of younger generations, in contrast, may have fewer preconceived ideas about mentally ill individuals, so there may be more opportunities to intervene on their beliefs and reduce stigmatization. Ultimately, over time, it would be ideal if mental illness were barely stigmatized at all. This
would open up more and more opportunities for those who are struggling with the effects of stigmatization on mental illness.

**Tackling Mental Health Stigma**

So, how can we as a society, and interpersonally, begin to decrease the stigmas surrounding poor mental health? One seminal experiment by Corrigan and colleagues (2001) investigated this question by examining three different strategies for minimizing mental health stigma: education, contact, and protest. Education has been shown to be one of the most powerful and important ways to reduce stigma regarding mental health. In a study done with graduate students it was shown that a brief course on mental illnesses reduced stigma and changed attributions regarding numerous illnesses (Morrison et al., 1980). Protest has also been shown to reduce stigma in a similar way to education, the approach is just less educationally centered and more geared towards lecture (Corrigan et al., 2001). Although the approach is less gentle, it still forces people to think about their ideas and thoughts about those with mental health issues. Contact with individuals experiencing mental health problems is thought to decrease stigma, but more information is needed to really make that claim. What has been found is that contact with other races decreases racial prejudice, leading these researchers to hypothesize that contact could have positive effects on the stigma of mental illness (Desforges et al., 1991). Although this would seem like a fair hypothesis, this is likely not to work with people who have severe illnesses like schizophrenia or bipolar disorder. What they have to say about their experiences with mental illness are likely to scare people, except for the rare few who are psychologically-minded.

The researchers conducting this study used 152 community college students randomly assigned to one of the three strategies, or a control group. Then, the college students were asked
to complete a questionnaire focusing on six groups of illnesses: depression, psychosis, cocaine addiction, mental retardation, cancer, and AIDS. It is important to note that AIDS and cancer are not considered mental illnesses but are very stigmatized in society nonetheless and will contribute to the research either way. The questionnaire probed participants’ attributions of the illnesses (i.e., ideas about why people have the illness and how controllable it is) as well as their attitudes towards people with the illnesses (i.e., whether people remembered positive or negative things about individuals with the illnesses in a vignette). The results showed that both the education and contact conditions improved people’s attitudes toward the illnesses, reducing stigma. Importantly, they also showed that changes in people’s attributions for the illnesses accounted for these changes in people’s attitudes. Through both education and contact, participants were able to understand the experience of people with mental illnesses and how those mental illnesses came to be. The more education you have or contact you can have with individuals experiencing mental illness, the more you can come to understand how the stigma surrounding these illnesses are no more than outdated anecdotes.

Stigma stemming from attributions isn’t just limited to mental illness either, and it can apply to a multitude of things. Just as an example, many formerly incarcerated individuals find it hard to get a job once they have been released (Visher et al., 2008). This may have a lot to do with attributions employers have about former prisoners, and doesn’t allow them the same opportunities as others who have not been incarcerated. This can also be applied to things like weight bias and homophobia, where attributions about an individual play a large part in the stigma attached to them (Peretz-Lange, 2021).
Biological and Experiential Attributions for Mental Health as a Source of Stigma

Because attributions play a critical role in mental health stigma, in this section I will explore literature that delves into how people think about biology versus experience (nature vs. nurture) as causing mental illness, and how this reasoning may play a part in the stigmatization of mental illness. When individuals think about what causes a mental illness, their beliefs will play a large role in their perception of that illness and how much judgment they may or may not impose. Of course, in reality, the roles of biology and experience are far from black and white – both types of causes play a role and even interact with each other – but individuals may be unaware of this and hold assumptions based on their cognitive intuitions or limited knowledge of the illness, leading to stigmatization.

A large body of work finds that biological explanations (ones citing genetics, inborn characteristics, or “nature”) reduce stigma toward mental illness. One great study that provides insight to this topic is a research paper written by Bogart and colleagues called “Born that way or became that way: stigma toward congenital versus acquired disability”. Although this paper focuses on both mental and physical disabilities rather than just on mental illness, it still provides insight into how people reason about biology versus trauma and tries to uncover which perspective is most damaging. It was found through survey testing in multiple different experiments that congenital disabilities were more stigmatized compared to acquired disabilities (Bogart et al., 2019). This was true even in cases of the same disability where the etiology was manipulated (e.g., congenital blindness vs. acquired blindness). The overall pattern of which illnesses where stigmatized the most versus the least also aligned with which illnesses are most likely to be congenital vs. acquired. Participants stigmatized people with mental illness the most, followed by intellectual disabilities, facial disfigurement, paraplegia, and lastly, blindness and
deafness. The study thus suggests that acquired disabilities are more stigmatized than congenital disabilities overall.

Another study suggesting that biological explanations for mental illness reduce stigma focused on changing middle schoolers’ attitudes about mental illness through education (Watson et al., 2004). This can be really important, especially since a lot of people struggle in their middle school years and can have a tendency to get persecuted for it. In this study, the researchers had two questions in mind: First, what are the baseline knowledge or attitudes about mental illness in this sample of middle school students? Second, does participation in a curriculum about the science of mental health increase knowledge and improve attitudes about mental illness? The two primary goals of the curriculum were to teach children that mental illness has a biological basis and can be diagnosed and treated, and that there are other reasons behind the onset of mental illness, like psychological and social trauma. To try and answer these questions, they surveyed 1,500 middle school students throughout the United States. They found that the curriculum showed significant improvements in both knowledge and attitudes surrounding those with mental illnesses and concluded that a brief educational program could be implemented to improve these stigmas in middle school children (Watson et al., 2004). Students has some understanding of what mental illness was and that it had to do with a problem in the brain, but their knowledge of biological vs psychosocial causes of onset was pretty much nonexistent, and it was noted that overall, they were “not sure” about the various aspects of mental illness (Watson et al., 2004). If a brief program such as this were to be implemented, attributions about those struggling with mental health problems would undoubtedly be lower in the younger generations and would lead to less stigma overall for those with mental illnesses.
Although the above studies both found that biological explanations led to more stigmatization, this may not always be the case. As CK and colleagues (2009) wrote, “it has been suggested that biological accounts de-stigmatize psychiatric problems and are to be preferred.” CK and colleagues used experimental manipulations to assess the effect of causal information on the perception of mental disorders. Participants were first put in one of three groups describing the cause of an illness; psychological causes, biological causes, and a control group (the cause is unclear). They were then asked to rate a range of problems within their specific condition. The results showed that participants in the psychological condition thought that those with mental illness were significantly more likely to recover and much less likely to harm themselves or others, compared to the biological and control conditions.

A final study by Phelan (2005) considered how research on genetics has evolved over the past hundred years, leading to a change in understanding of human behavior as being highly based on genetics. Phelan predicted, “if such ideas are commonly accepted, geneticization should exacerbate stigma by increasing perceptions of differentness, persistence, seriousness, and transmissibility, which in turn should increase social distance and reproductive restrictiveness.” The researcher tested this hypothesis using a vignette experiment in a nationally representative survey. Just as hypothesized, genetic attributions surrounding mental illness led to more stigmatization. Participants described genetic causes of mental illness as more serious and persistent and believed that the siblings and children of such individuals would develop the same problems.

Through the above section one can see that stigma regarding biological explanations for mental illness is not so cut and dry. While a lot of literature suggests that biological explanations create more stigma, there is evidence of the opposite effect in other studies. It is clear that
biological explanations affect stigma, and there is a good amount of research regarding the subject. What has seldom been investigated though, are the effects of experiential/trauma related explanations for mental health stigma. This is a gap in the psychiatric literature that I plan to fill with the current study.

**How do Attributions Impact Stigma?**

One study examined adolescents’ perceptions of peers with depression, and argued that attributions may shape stigma by influencing “inferences of personal responsibility” (Dolphin & Hennessy, 2014). The participants in the study were 401 tenth grade students with an age range of 14-17 years old. Dolphin and Hennessy (2014) employed structural equation modeling to assess the relationships among causal attributions, perceived responsibility, and reported emotions toward and social acceptance of an imagined peer with depression. The results indicated that if the peer was thought to have had little to no control over the cause of their depression, responsibility of the mental disorder was much less and therefore the illness was less stigmatized. These findings suggest that humans are much more understanding, feel more pity, and are generally less stigmatizing towards individuals with mental disorders if the individual with the disorder is thought to have no responsibility for the diathesis of their illness. If individuals place more responsibility of contraction on certain illnesses, it could potentially explain why many illnesses are more stigmatized than others.

Another study with similar implications explored stigmas of various mental and physical health stigmas (Weiner, 1988). A sample of 59 UCLA students participated in this study by responding to several different questions pertaining to various stigmas. The results showed that physical disabilities like blindness, where there is no perceived responsibility of onset, was much
less stigmatized than mental illness. This again shows that stigma seems to come from a place of blame on the individual suffering from the illness.

**The Present Study**

I have reviewed evidence that mental illness stigma is a pervasive problem, and that manipulating attributions for mental illness may be a promising way of reducing this stigma by shifting perceptions of blame. Evidence is somewhat mixed on how biological explanations (i.e., those citing genetics, inborn characteristics, or “nature”) for mental illness may impact stigma. The present study will add to this literature. I hypothesize that increased endorsement of biological explanations will predict reduced stigma, in line with most research on this topic. More importantly, the present study will also examine how experiential attributions (i.e., those citing trauma, experiences, or “nurture”) for mental illness impact stigma – a question which little research has explored. I hypothesize that experiential explanations will also reduce stigma by reducing perceptions of controllability or blameworthiness, though I predict this will be weaker than the effect of biological explanations. Finally, I also hypothesize that certain illnesses will be more stigmatized than others, so the effects of different explanations might differ across different illnesses. This will give insight into how people with mental illness are more or less affected by stigma depending on what illness they have. In sum, the present study will serve to examine stigma related to mental health issues, determine which attributions are related to the most stigma, and highlight some steps forward for how to help society and the world as a whole lower the stigma around psychological illnesses.

**Method**
**Participants**

In this study, a total of 82 participants (50% Female, 49% Male, and 1% Non-Binary) were recruited through Prolific. The demographics in terms of race and ethnicity were: 1% Asian, 22% Black/African American, 20% Hispanic/Latino, and 57% White/Caucasian. Participants were sourced from around the globe, including South America, Europe, and Africa, providing a broader view of mental health stigma and ensuring greater variance in beliefs about the causes of mental illness. All participants were fluent in English. The ages of these participants ranged from 18 to 62 (M = 25.098, SD = 7.155). Participants were compensated for their participation with United States currency.

**Materials**

Several software programs were used to create the survey (Qualtrics), acquire participants (Prolific), clean and organize the data (Excel), and conduct analyses (JASP and Jamovi). When all the results from the survey were in and all the participants were awarded monetary compensation, all the data collected was moved to Excel. In Excel all of the data was cleaned, sorted and computed and was then moved to software called JASP and Jamovi for analysis.

**Procedure**

Participants first read and agreed to the consent form, and provided their Prolific ID so that they could receive compensation. Next, they progressed through several phases of the study: a causal explanation assessment, stigma assessment, and finally, a demographic questionnaire.

*Causal explanation assessment*. In this set of questions, the goal was to understand what participants thought caused various mental illnesses. We specifically focused on six
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psychological disorders: Depression, Anxiety, Post-Traumatic Stress Disorder, Anorexia, Dissociative Identity Disorder and Schizophrenia. These six disorders were chosen based on our expectation that participants had likely heard of them and based on the fact that they represent a wide variety of actual etiologies (biological vs. experiential). For each disorder, participants were first asked if they had heard of the disorder. If they answered no, the survey skipped them past the questions concerning that disorder and moved to the next disorder. If they answered yes, the survey presented them with the causal explanation questions where participants were asked to rate their agreement to the following two questions: “This disorder is caused by people’s biology (e.g., brain chemistry, genetics, inborn predisposition)”, and “This disorder is caused by people’s experiences (e.g., childhood experiences, trauma, treatment by others)”. Participants were to answer each question on a 1-7 scale of agreement, where 1 was labeled “completely disagree” and 7 was labeled “completely agree”. Note that although it is intuitive that these responses might be related to one another (e.g., the more a disorder is caused by biological factors, the less it may be caused by experiential factors), our survey did not assume this, and presented these questions independently. Participants responded to these rating questions for each illness until the causal explanations assessment was completed.

Stigma assessment. Next, participants moved on to the stigma assessment. We used a scale drawn from a study by Watson and colleagues (2004). The scale was presented separately for each of the six psychological illnesses mentioned above. For each item in the scale (see Table 1), participants were asked to rate their agreement on a 1-7 likert scale.

<table>
<thead>
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<th>Table 1. Stigma assessment questions</th>
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<tr>
<td>A person with [disorder] is not dangerous.</td>
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<td>A person with [disorder] should be locked in a mental hospital.</td>
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I try to stay away from people with [disorder].

I am scared of people with [disorder].

**Demographics questionnaire.** After participants completed the stigma assessment, they were brought to the demographics section of the study. In this section, participants were asked about their racial/ethnic background, gender, personal income, age, family history of mental illness, as well as whether they work in the field of mental healthcare or the field of healthcare in general.

Once participants completed the study, they were brought to the debriefing form and given a completion code, which allowed them to receive compensation.

**Results**

Our first analysis focused on the relation between overall explanations for mental illness and overall mental illness stigma. For each participant, we calculated their average biological cause rating (across all disorders), average experiential cause rating (across all disorders), and average stigma rating (average of the stigma scales across all disorders). We then conducted a linear regression to predict stigma ratings based on biological cause and experiential cause ratings. The regression was not significant overall, $F(2,79) = 1.47$, $p = .24$, but revealed a marginally significant effect of experiential cause ratings ($p = .09$), trending in the direction of a negative relationship. In other words, the more participants viewed mental illness as caused by people’s experiences, the less they tended to stigmatize mental illness, though this trend did not quite reach significance. (See Figure 1).
Figure 1. Null relation between biological explanation ratings and stigma, and marginally significant negative relation between experiential explanation ratings and stigma.
Next, separate linear regression models were conducted on each individual mental illness. For each mental illness, a regression was conducted in order to examine how stigma ratings of that illness were predicted by biological cause and experiential cause ratings of that illness. Of these analyses, the only one reaching even marginal significance was for schizophrenia, F(2,76) = 2.58, p = .08. This analysis revealed a marginally significant negative correlation between biological explanation ratings and stigma (p = .07) and a marginally significant negative correlation between experiential explanation ratings and stigma (p = .09), as shown in Figure 2. In other words, the more participants viewed schizophrenia as caused by biology or by experiences, the less they tended to stigmatize mental illness, though this trend did not quite reach significance.
Figure 2. Null relation between biological explanation ratings and stigma, and marginally significant negative relation between experiential explanation ratings and stigma.
A final set of analyses focused on within-subject differences in ratings of different disorders. First, a mixed-effects model regression was conducted to examine whether there were differences in ratings of different disorders. The model included disorders as a fixed factor, as well as random intercepts for participants, and was significant overall, $F(5,394) = 32.0, p < .001$, suggesting that different disorders were stigmatized to different extents. In particular, the most-stigmatized disorders by far were schizophrenia and anorexia, as shown in Figure 3.

![Figure 3. Differences in stigma ratings across the six disorders presented to participants.](image)

Next, ratings of biological and experiential causes were added to the model in order to examine whether the impacts of these ratings on stigma might differ across different disorders. The model revealed a significant main effect of experiential cause ratings ($p = .007$), suggesting that the more participants viewed mental illnesses as caused by experiences, the less they
stigmatized them (in line with the results described above, but taking into account between-disorder differences in stigmatization). Moreover, the model revealed that this relation was relatively consistent across different disorders (see Fig. 4); in other words, there was no significant interaction between disorder and experiential cause ratings on stigma ratings ($p = .67$). However, while this interaction did not reach significance, Figure 4 suggests that the association between experiential cause ratings and stigma was particularly strong for certain illnesses (e.g., anorexia, PTSD) and less strong for others (e.g., anxiety, depression – disorders for which stigma was low at baseline).

*Figure 4.* Differences in relations between experiential cause ratings and stigma across the six disorders presented to participants.
Discussion

My hypothesis was that biological explanations for mental illness would predict reduced stigma, and that experiential explanations would also predict reduced stigma but to a lesser extent. The results of this study showed some evidence that biological explanations predicted reduced stigma (though often this relationship was not significant). In contrast to my hypothesis, however, experiential explanations for mental illness were more strongly associated with reduced stigma. In regard to schizophrenia in particular (a highly stigmatized mental illness), my results showed that both biological and experiential explanations were associated with reduced stigma regarding the illness. This suggests that when individuals simply have any explanation for why someone is mentally ill, stigma is reduced. These results show that it is more important overall to have an explanation for mental illness rather than none at all. Since many prior studies have focused more on the effects of biological explanations, it is noteworthy that experiential explanations can also play a role in reducing stigma.

The result is important, and perhaps promising because it indicates that education surrounding mental health can be hugely beneficial for the stigmatization of those with psychological problems. Schools should implement programs to teach children about how mental illnesses reveal themselves and where they come from. It is paramount to teach children about how there are more than one cause for mental illnesses. For the most part a mixture of experiences and biology create a diathesis for certain illnesses in certain individuals. There is a lot of focus in the media about how biology creates mental illnesses because of parents’ and grandparents’ DNA, which can have an impact, but it is rarely mentioned how trauma and experiences are just as important if not more in creating a diathesis for mental illnesses. The educational interventions reviewed in the Introduction focus just on discussion of biology as a
cause, rather than trauma or a mix of biology and trauma. It is important that even in early childhood, children are taught to think accurately about mental illness, because the more educated kids are, the less stigma they will have towards individuals struggling with mental illness once they are older.

My other hypothesis was that certain illnesses would be stigmatized more than others. I was interested in which illnesses would be most stigmatized and which ones would be the least stigmatized, especially from our culturally diverse sample. It was no surprise to me that depression and anxiety showed the lowest levels of stigma. Most people struggle with anxiety and depression at some point, and since it has become so common, people are less likely to judge those who have it. I was also unsurprised that schizophrenia showed the highest amount of stigma. This makes sense, especially with the way schizophrenia has been depicted in movies and books (for example, the move “A Beautiful Mind” starring Russel Crowe). What I found interesting was that anorexia was stigmatized just as much as schizophrenia. These results raise the question of what makes anorexia so stigmatized. When people think of someone with schizophrenia, they often picture the worst case scenario. I think this is why a lot of people stigmatize anorexia so strongly as well. Anorexia is a scary and detrimental disorder, where the individual is so hard pressed on losing weight, they will starve themselves for days or weeks at a time. It leaves them looking horrifically skinny and emaciated, and quite honestly it’s scary. As discovered throughout a lot of the previous research explored earlier in this study, a lot of stigma surrounding mental health comes from fear, thus the high amount of stigma surrounding anorexia is really not that surprising.

It was also interesting to see that DID was less stigmatized than schizophrenia and anorexia. The depiction of DID in books and movies makes it seem as though people who suffer
from this illness can be dangerous and unpredictable, and thus I expected it to be highly stigmatized. This makes me wonder if it was due to) the wording of my questions about DID. For a long while, DID was known as Multiple Personality Disorder. Although this prior name was written in parentheses next to DID in the survey, and we specifically confirmed that participants had heard of DID, participants may still have been unclear about the disorder. This limitation could be easily addressed in the future by using the original name given to mental disorders (so long as they aren’t offensive) instead of the newer, less mainstream names given in the last 10-15 years.

These differences in baseline levels of stigma also allowed us to examine differences in the relations between explanations and stigma across different disorders. For example, stigmas toward depression and anxiety did not vary much in relation to different explanations, likely due to the fact that these stigma levels were low to begin with. For schizophrenia and anorexia on the other hand (illnesses shown through this study to be highly stigmatized), there were stronger relations between stigmas and explanations.

All these findings culminate into one big reason behind this whole study. Stigma surrounding mental health is pervasive and intrusive in society and the world. People who struggle with mental health problems are looked at differently and usually not given the same opportunities as the rest of society. This should not be the case, therefore finding out what exactly causes the most stigma, why that is, and how to fix it seemed an important endeavor. Through the research of past studies and this one, it seems clear that mental health stigma is largely due to the pitifully small amount of education surrounding mental health. This is important information, and proper education surrounding mental could be a very successful way to reduce stigma surrounding mental health, possibly before the stigma is even formed. It’s
important that this education is instilled early in children and young adults, so that any feelings of stigma are not yet cemented and can be changed. If mental health can become something talked about regularly, and people begin to understand it more, the stigma surrounding these illnesses will go down. There is a link between explanation ratings and stigma, and if education about the explanations for mental illnesses can be increased, then stigma surrounding mental health can surely be decreased. It’s important to mention that although explanations impact stigma, it could also be the other way around (stigma impacts explanations). Even if stigma impacts explanations, those with the most stigmatizing views of mental illness would have the least educated explanations for that illness, therefore education on the diathesis of illnesses would still serve to reduce stigma. If good mental health education can be implemented in schools, kids will grow up thinking about mental health in an educated and non-biased manner. It could create a society where mental health, no matter the diagnosis, is treated with respect and understanding rather than disgust and distrust. Through the findings of this study, it seems the illnesses most prone to stigmatization are the ones in which people are least familiar with. Through education and time, it could be possible to get to a point where mental health issues are a normality of the human experience.


References


