

Cohorts & Perceived Social Stigma of Mental Illness by Education

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**Abstract**

Using data from the 2006 General Social Survey, I analyze the cohort effect on perceived social stigma towards the mentally ill, controlling for college education. This analysis relies on applying life course perspective (Elder, 1994; 1998) and Arnett's emerging adulthood (2000) to the historic context of mental illness stigma in the United States. I hypothesized that younger cohorts would have less stigmatized views of the world due to the environments they were socialized in, with college education neutralizing the cohort effect because educated people tend to perceive stigma more accurately (Gonzalez, 2007); this hypothesis was supported. This analysis is proposed because it is a method of analyzing whether or not the United States seems to be developing a less stigmatizing environment towards the mentally ill; this is important because of the influence that a fear of rejection and stigma can have towards a mentally ill individual's decision to seek treatment.

When Social Psychologists began investigating individuals with mental illnesses, they noticed that people showed hesitance to pursue a treatment for their illnesses because of a perceived (and real) social stigma (Crisp, 2000; Link, 1987). As time passes, more and more efforts are being made to reduce the stigma of having a mental illness: legislation is passed, committees make campaigns, and schools attempt to educate their students (National Institute of Mental Health, 2013; Scull, 2015). Because of the different levels of social awareness of mental health various cohorts grow up in, I hypothesize that individuals from older cohorts will perceive more social stigma to having a mental illness. Using the 2006 General Social Survey (GSS) data, I compare two variables: cohorts (young adult (18-29), middle adult (30-54), and elderly adult (55+)) and perceptions of how much social stigma was attached to telling others that one has received a treatment for a mental illness in society.

Cohorts, however, are not the only factor in determining perceived social stigma to the mentally ill: another key variable is education; educated individuals tend to have different perceptions of the mentally ill than the non-educated (Bobo, 1989). Because younger cohorts tend to be more educated (U.S Bureau of Census, 2015), a relationship shown between cohorts and perceived stigma may depend on education level. Because of this, I will also be analyzing the association between cohorts and perceived social stigma while controlled for education level.

It is important to examine whether or not there is a cohort difference in perceived social stigma because it is a way to indicate progress in society's attempt to reduce the stigma of having a mental illness. If there is less stigma surrounding having a mental illness, people may be less afraid to seek treatment and let their friends know what they are going through – which is the foundation of having a strong social support network. Seeking treatment and having a strong support network are important parts of recovery (George, Blazer, Hughes, & Fowler, 1989;

Davidson, Chinman, Sells, & Rowe, 2006), and as long as perceived stigma still exists, people who need help may never seek treatment. By analyzing the relationship between cohorts and whether or not one thinks that coming out as mentally ill would cause someone to lose friends, research can begin to investigate if the perceived social costs of being “out” as mentally ill have begun to reduce.

### **Previous Research**

The history of mental illness stigma matters because of the way it shapes people’s views toward the mentally ill; life context can be a major factor in how one perceives the world (Elder, 1994; 1998). According to life course theory, developed by Elder (1994; 1998), the environment that one grows up and lives in has an important impact on psychological states, how the world is perceived, and general understandings of the world. Two important concepts from this perspective are the effects of historical time in which one lives and the timing of events at specific stages of life. The historic context is relevant because of its effects on socialization – how one is socialized is partially dependent on the time period in which one is socialized because different time periods tend to have different norms. The timing of events at specific stages of life is important because differing developmental stages have different perspectives on events; for example, historic events that occur in early childhood would not be as influential as those that occurred during adulthood, since young children are not as effected by such events.

The importance of the historical timing is furthered by a recent theory of emerging adulthood (Arnett, 2000), which focuses on life development in peoples aged 18-25 and how this period of independence effects the formation of world views (Arnett, 2000; Munsey, 2006). Differing contexts of childhood and emerging adulthood leave cohorts with different perspectives of the world, and since there has been a progression of mental illness awareness and

increased positive legislation, it may follow that perceived stigma towards the mentally ill would also vary by cohort.

In the youngest cohort's (the emerging adults, born 1977-1988) formative years, many key legislations were passed; through the late 1970s and 1980s, there was a large increase in mental health awareness and reform (National Institute of Mental Health, 2013; Unite for Sight, 2015)). Applying the life course perspective and Arnett's theory of emerging adulthood to the history of mental illness stigma, it can be considered that because the youngest cohort of emerging adults in 2006 had a less stigma inducing childhood environment, they may report less perceived social costs to being "out" as mentally ill. By contrast, mental health legislation was only just beginning to reform during the middle adults' lifetime (born 1952-1976). For example, 5 years before their birth, there was the very first governmental attempt at forming a mental health institute and, 2 years after their birth, the first nationwide study of the status of mental health hospitals and views) (National Institute of Mental Health, 2013). The oldest cohort (born in 1951 or earlier) had little to no mental health reform during their formative years, and due to them already having reached adulthood during key mental health reforms, their opinions would have already been formed in a more stigmatized manner.

Literature analyzing cohort differences in people's perception of mental illness stigma is scarce, as literature on mental illness stigma tends to focus on personal prejudice instead of perceived stigma in the world. A study done by Phillip J. Leaf (which was the only study I could find that analyzed world views instead of personal prejudice) found age to be a significant correlate in the youngest cohort (18-24 year olds), which perceived less social stigma towards the mentally ill (in the form of "Family would get upset"). In addition, Leaf's study supported that the youngest cohort was a significant correlate to less perceived barriers in access to mental

health care and in less personal prejudice towards the mentally ill (Leaf, 1987). Leaf's study is one of few that analyze perceived stigma instead of personal prejudice, which makes it a key example of my variables in use. However, even Leaf's study focuses primarily on personal prejudices (such as whether or not the respondents would consider using a facility if they needed one), which makes only a small portion of the study directly applicable to my research question.

There is also literature, however, which found age to be significant towards having more negative personal prejudice, such as Gonzalez's study on demographic variables relationship with age, gender, and race. In this study, young people were found to have significantly more negative views towards the mentally ill than other cohort, though it should be noted that this study focused on personal prejudice, not on perceived social stigma at large. The focus of my study on how respondents perceive the world's stigma towards the mentally ill makes literature such as Gonzalez's study relevant, but not measuring the same concept. I hypothesize that there will be a difference in how my measurements result (which focus on the world) and how measurements of personal prejudice resulted.

Literature on the effects of education shows a consistent trend. There are studies on personal prejudice that show that educated individuals tend to hold less personal prejudice (Bobo, 1989), but studies that are more precise to my variable of perceived world prejudice tell a different story. According to a study by Gonzalez (2007), educated caregivers had more accurate perceptions of stigma for their patients. This implies that people who have been educated may be less effected by the cohort effect because of their overall awareness of mental illness stigma.

Overall, the literature seems split on whether or not cohorts are significantly correlated towards prejudice of the mentally ill. However, my study differs from the literature in a key regard: I am measuring perceived social stigma – in other words, whether or not the respondent

thinks there is a stigma towards the mentally ill; most literature, by contrast, measures personal prejudice from the respondent. These differences make it difficult to directly apply previous research on cohorts to the project, but theoretical frameworks and literature seems to support my hypothesis. Because of previous research and theoretical frameworks, I believe that younger cohorts will perceive less social stigma towards the mentally ill, but that educated peoples will have overall accuracy, negating the cohort effect.

### **Data & Methods**

I use the 2006 General Social Survey (GSS) data for my analysis (n=4510) The General Social Survey is a national survey of adults from across the contiguous United States (though it does not include respondents who were currently serving in the military, abroad, or institutionalized) conducted by the National Opinion Research Center, which is based out of the University of Chicago. I am using this older data set because it is the most recent (and only) year in which the question I used to measure perceived social stigma towards the mentally ill was asked; this is because the 2006 General Social Survey had a special topical module on mental illness perceptions (National Opinion Research Center, 2015a). The data used is cross-sectional in nature because the topical module was only conducted once, which does not allow for a longitudinal study.

For my measurement of perceived social stigma, I chose to focus on whether or not respondents thought that if someone were to “come out” as mentally ill, they would lose friends. I operationalized this by using a question in which respondents were read a vignette (see Appendix A) and then responded to “For the next several questions, please tell me whether you strongly agree, agree, disagree, or strongly disagree with the statement. b. If [NAME] let people know (he/she) is in treatment, (he/she) would lose some of (his/her) friends.” I reduced the

response categories into a dichotomous measurement of perceived stigma: “no stigma” (64.5% of the sample) or “stigma” (35.5% of the sample) (Table 1). The vignettes read to the respondents varied, with one vignette describing a physical illness, one depression, and one schizophrenia. Because I only wish to investigate mental illness, I only utilize responses from respondents who were read the vignettes that describe depression and schizophrenia, not the ones describing a physical illness. Out of the initial 4,510 respondents to the 2006 GSS, 1,518 were read the vignette sections, and only 1,119 were read the mental illness vignettes.

The cohorts are divided into three age categories: emerging adulthood (18-29 year olds, 15.9% of the sample), middle adulthood (30-54 year olds, 54.7% of the sample), and late adulthood (55+ year olds, 29.5% of the sample) (Table 1). I chose this distribution of ages because research supports the idea that opinions are formed during developmental and adolescent years (Arnett, 2000; Munsey, 2006) and life contexts effect points of view (Elder, 1998). In addition, I chose this distribution because it is a similar distribution that Leaf (1987) used in his study (which had cohorts of 18-24, 25-64, and 65+ years old).

Finally, I measured or not the respondent had ever been in college as a control variable in a dichotomous category of “no college” (47.4% of the sample) and “college” (52.6% of the sample) (Table 1). I chose a dichotomous distribution because of the small analytical sample, which does not allow for more than two divisions of the control variable without risking ungeneralizable results, and because previous research supports the idea that exposure to a college education is important in the formation of opinions (Bobo, 1989).

## **Findings**

My data analysis supports my hypothesis: according to the data, cohorts have a significant effect on perceived social stigma of being “out” as mentally ill ( $p \leq .01$ ). As the

cohorts got older, they perceived more stigma – of the cohorts, 40.4% of the late adults perceived stigma, 36.0% of the middle adults perceived stigma, and 25.9% of the emerging adults perceived stigma (Table 2).

When the control variable (whether or not the respondent has been exposed to a college education) was added to the analysis, significance levels reduce. As I hypothesized, controlling for a college education makes the relationship between cohorts and perceived social stigma insignificant ( $p > .05$ ) (for the oldest cohort, 39.7% perceived stigma; for the middle cohort, 36.3% perceived stigma; for the emerging cohort, 30.1% perceived stigma). However, among those without a college education, cohorts are still significant ( $p < .05$ ) (for the oldest cohort, 41.1% perceived stigma; for the middle cohort, 35.4% perceived stigma; for the emerging cohort, 21.6% perceived stigma) (Table 2). It should be noted, however, that this division of respondents left numerous categories with very few numbers of cases – in particular, both of the groups of 18-29 years old who perceived stigma were less than 25 (16 respondents for non-college educated and 22 for college educated). These low numbers bring the significance into question, and this test would need to be repeated with a larger sample to further support the control variable's potential influence on the dependent and independent variables.

## **Discussion**

Mental illness is heavily stigmatized in the United States, which can have devastating effects on a mentally ill individual to point of making their illness worse or by influencing the decision to seek treatment (Crisp, 2000; Link, 1987). Efforts have been made by both federal and non-governments organizations to research mental illness and reduce stigma, but measurements of this effectiveness have been limited to studies on personal prejudices towards the mentally ill in the past. Having an empirical analysis of world views – in other words, perceived stigma – is

important. Mentally ill persons tend to make decisions about whether or not they seek help on how they *think* people will react, not necessarily how they will *actually* react (Link, 1987). One method of finding out how much progress has been made on the reduction of perceived stigma is to analyze cohorts' perceptions, as done in this study.

My hypothesis was supported – cohorts seem to have some significant differences on perceived social stigma in the world, though only amongst the uneducated. I theorize that this is because education negates the socialization effect to some degree; the socialization received on a college campus can negate the stigmatizing past that respondents may have had, which would make cohorts non-significant. However, the younger non-college exposed respondents perceived significantly less prejudice towards the mentally ill in society than the older cohort, which I believe to partially be because of the socialization that each cohort had as a child. It should be noted that the educated younger cohort perceived more stigma than the non-educated younger cohort – these results further support Gonzalez's data, which proposed that educated individuals perceive stigma more accurately than non-educated individuals (2007).

The results from this analysis show a promising trend towards lessened social stigma for the mentally ill. It is important to note, however, that even the youngest cohort perceives quite a bit of stigma in the world (25.7%) and the oldest even more (40.3%); there is still considerable progress to be made in reducing the perceived social stigma of being mentally ill. Perhaps more of an effort should be put on education, as these respondents tended to perceive less stigma – perhaps there simply needs to be a generally greater effort towards awareness and acceptance. No matter what however, the work is not done, even if people are moving towards less stigmatizing views. It is important that our society continues to work towards reducing stigma

towards mentally ill populations so that they might get more help and, in the end, be able to move forward on the road towards recovery.

My results are in agreement with Leaf's study on demographic variables effects on stigma towards the mentally ill (Leaf, 1987), but contradicts the findings from Gonzalez on the same subject (Gonzalez, 2005). I believe some of this discourse may be because Gonzalez's study focused on personal prejudice more so than perceived social stigma, which Leaf's study included. Again, literature focuses primarily on factors that influence personal prejudice towards the mentally ill, rather than perceived social stigma, which makes it difficult to directly apply most research towards my study.

Weaknesses in this study are, primarily, sample size and limited measures of the dependent variable. Sample sizes were too small to form conclusive results of the three variable analysis, which left certain cells with less than 25 people ( $n < 25$ ), which is a weakness in the results. Secondly, perceived social stigma was only measured by one variable, as the GSS only has one question that can be used to measure this variable. If this research were to be continued, a different data set may need to be consulted (or created) which has more measures of perceived social stigma in the world using various questions for the respondents to answer. In addition, the GSS data is cross-sectional, which does not allow for a longitudinal study of attitude adjustment as cohorts age.

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Table 1. Percentage Distribution for Recoded Variables	
Perceived Social Stigma in the World [N=940]	
No Stigma	64.5
Stigma	35.5
	100.0
Cohort [N=1015]	
Emerging Adults (18-29 year olds)	15.9
Middle Adults (30-54 year olds)	54.7
Late Adults (55+ year olds)	29.5
	100.0
College Education [N=1014]	
No	47.4
Yes	52.6
	100.0

Table 2. Crosstabulation of College Education by Perceived Social Stigma & Cohort (%)					
	Total [N=934]				
	Emerging Adults (18-29)	Middle Adults (30-54)	Late Adults (55+)	Total	$\chi^2$
No Stigma	74.1	64.0	59.6	64.2	$p \leq .01$
Stigma	25.9	36.0	40.4	35.8	
Non-College Educated [N=421]					
	Emerging Adults (18-29)	Middle Adults (30-54)	Late Adults (55+)	Total	$\chi^2$
No Stigma	78.4	64.6	58.9	65.1	$p < .05$
Stigma	21.6	35.4	41.1	34.9	
College Educated [N=513]					
	Emerging Adults (18-29)	Middle Adults (30-54)	Late Adults (55+)	Total	$\chi^2$
No Stigma	69.9	63.7	60.3	63.5	$p > .05$
Stigma	30.1	36.3	39.7	36.5	

## Appendix A

Type 1 (Symptoms of Depression): [NAME] is a [RACE] [GENDER]. For the last several weeks [NAME] has been feeling really down. [S/he] wakes up in the morning with a sad mood and heavy feeling that sticks with [him/her] all day long. [S/he] isn't enjoying things the way [s/he] normally would. In fact nothing seems to give [him/her] pleasure. Even when good things happen, they don't seem to make [NAME] happy. The smallest tasks are difficult to accomplish. [S/he] finds it hard to concentrate on anything. [S/he] feels out of energy, out of steam and cannot do things [s/he] usually does. And even though [NAME] feels tired, when night comes [s/he] can't go to sleep. [NAME] feels pretty worthless, very discouraged, and guilty. [NAME]'s family has noticed that [s/he] has lost appetite and weight. [S/he] has pulled away from them and just doesn't feel like talking.

Type 2 (Symptoms of Schizophrenia): [NAME] is a [RACE] [GENDER]. Up until a year ago, life was pretty okay for [NAME]. But then, things started to change. [S/he] thought that people around [him/her] were making disapproving comments, and talking behind [his/her] back. [NAME] was convinced that people were spying on [him/her] and that they could hear what [s/he] was thinking. [NAME] lost [his/her] drive to participate in [his/her] usual work and family activities and retreated to [his/her] home, eventually spending most of [his/her] time on [his/her] own. [NAME] became so preoccupied with what [s/he] was thinking that [s/he] skipped meals and stopped bathing regularly. At night, when everyone else was sleeping, [s/he] was walking back and forth at home. [NAME] was hearing voices even though no one else was around. These voices told [him/her] what to do and what to think. [S/he] has been living this way for six months.

Type 3 (Symptoms of a Physical Illness): [NAME] is a [RACE] [GENDER]. [NAME] has a history of breathing problems. [NAME] often has bouts of coughing at night, and doesn't sleep very well. [His/her] family and friends have noticed that these problems seem to be particularly bad during challenging situations, in the spring and fall and during strenuous activities. [NAME] used to enjoy playing tennis but recently gave it up because of these problems. [NAME] feels badly about [his/her] breathing problems, which seem to be getting worse, and wishes [s/he] could "be just like everyone else." [NAME] is involved in several activities and hobbies, and shares these activities with several friends. (National Opinion Research Center, 2015)