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Brief battery for measurement of stigmatizing versus affirming attitudes about mental illness

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ABSTRACT

Decreasing the stigma of mental illness is not sufficient. Rather promoting important ideas, such as recovery, empowerment, and self-determination, is important to increase social inclusion, or more broadly, affirming attitudes. The goal of this article is to evaluate the psychometrics of a battery of measures that assess both stigmatizing and affirming attitudes toward people with mental illnesses. The aforementioned battery was used in four separate RCTs on stigma change with different samples: college students, adults, health care providers, and mental health service providers. Test–retest indices were satisfactory for all samples except for the Empowerment Scale score for the mental health providers. Attribution Questionnaire-9 (AQ-9) scores were significantly and inversely associated with the three affirming attitude scale scores for eight of twelve correlations, with five of these meeting the Bonferroni Criterion. Research on social attitudes and structures needs to incorporate assessment of affirming perspectives about a group and effective anti-stigma programs need to promote social inclusion and affirming attitudes.

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1. Introduction

Advocates and researchers agree; stigma significantly impedes the life opportunities of people with serious mental illness. For this reason, many anti-stigma programs have emerged in the past decade to address public stigma and promote societal inclusion (Hinshaw, 2006; Thornicroft, 2006). Their goal has been to diminish the stereotypes and discrimination that comprise stigma and typically emerge in self-report measures as attitudes (Corrigan and Shapiro, 2010). Yet evaluating stigma is not sufficient; absence of stereotypes does not promote social inclusion (i.e., communities accepting people with psychiatric disabilities, encouraging their goals, and providing appropriate support in the process). The goal of this paper was to test the psychometrics of a brief battery of measures that reflect both stigmatizing and affirming attitudes; a battery that might be used to test the impact of anti-stigma and socially inclusive programs.

Researchers have distinguished public stigma (the impact of population-endorsement of the stigmatizing attitudes) from self-stigma (the impact of internalizing those attitudes) (Sartorius and Schulze, 2005). Public stigma, the focus of this paper, has been described in terms of cognitive behavioral structures that have developed out of social psychology: stereotypes, prejudice, and discrimination (Corrigan, 2005; Nelson, 2009). Stereotypes are common beliefs about a social group and, for people with mental illness, include dangerousness and responsibility. Stereotypes are learned by most people in a cultural group and are therefore inescapable. Prejudice is the egregious consequence of stereotypes: people agree with the beliefs ("That's right. People with mental illness are dangerous."), leading to emotional reactions ("Because they are dangerous, I fear them."). Other emotional reactions related to the stereotypes of mental illness are pity and anger. Discrimination is the behavioral consequence and may include social avoidance or endorsement of treatment coercion and institutionalization (Corrigan, 2005; Nelson, 2009). Stigma change programs target stereotypes and their discriminatory consequences. Social attitudes need to reflect affirming perspectives about a group as well, including efforts to assess inclusion of the outgroup among the opportunities available to the majority. Social inclusion broadly speaking has been defined as a societal *zeitgeist* that promotes perceived and real access to the economic, interpersonal, spiritual, and political resources available to all adults that are necessary for obtaining their personal goals (Leff and Warner, 2006; Lloyd et al., 2008). Three important conceptual evolutions in the mental health system – recovery, empowerment, and self-determination – have influenced ideas of social inclusion, or what we more broadly construe as affirming attitudes. Affirming attitudes include notions that people with mental illness recover, that they should determine for themselves life and

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treatment goals, and that they should have personal power over their life.

Recovery reintroduces ideas of "future and aspiration" to describe serious mental illness. Classic notions of mental illness, represented by Kraepelin's (1902) *dementia praecox* for example, described schizophrenia as marked by a progressive downhill course with prognostic expectations of never being able to live independently, work, marry, or have children. Long term follow-up studies, however, contradict such pessimism, finding that most people with mental illness are able to live a quality life in a community outside the mental health system (Harding et al., 1987; Ogawa et al., 1987; Harding et al., 1992; DeSisto et al., 1995; Harrison et al., 2001). This has led to psychiatric services that now foster hope in terms of attaining the person's goals.

Out of recovery comes empowerment, the idea that people with mental illness must have final authority not only over their treatment, but over the life goals that direct it. This means people with mental illness need to be of equal status with family members, service providers, and others involved in the person's life trajectory. Research has found empowerment to include five recurring themes: self-efficacy and self-esteem; powerlessness; optimism/control over future; righteous anger; and group/community action (Rogers et al., 1997; Rogers et al., 2010). Some people believe personal empowerment and self-determination are different sides of the same coin. More specifically, self-determination is promoted by helping persons grasp personal empowerment for themselves as well as by directing the community not to erect barriers to the process. It is more transparently anchored in the belief that people with serious mental illness do have goals (e.g., want to go back to work, live independently, and/or enjoy intimate relationships) and in the notion that these goals should be pursued and are achievable.

Our group has conducted four stigma change evaluations over the past 3 years. As a result of previous research, surveys of the literature, and participatory action research, we developed a brief battery that assessed both stigmatizing and affirming attitudes (Harding et al., 1987; Ogawa et al., 1987; Harding et al., 1992; DeSisto et al., 1995; Rogers et al., 1997; Harrison et al., 2001; Hinshaw, 2006; Leff and Warner, 2006; Thornicroft, 2006; Lloyd et al., 2008; Rogers et al., 2010). We sought to keep it brief as advocacy-based, anti-stigma programs around the world continue to search for assessment tools that can be feasibly used in the public sector. This article summarizes the reliability and convergent validity of the measures comprising this brief battery.

2. Method

2.1. Participants

Research participants for the findings reported here participated in one of four separate studies on stigma change. Each of these studies received prior Institutional Review Board approval. The first study relied on rigorous experimental control in a lab setting and hence was limited to college students with recruitment conducted via flyers posted around a Midwestern university campus (N=35). The second sought to test a stigma change program in an online format and included adult community members recruited through Craigslist, a collection of online resources including solicitations to participate in e-surveys (N=203). The third explored the impact of online news stories about mental health on health care providers with recruitment again through Craigslist (N=227). The fourth examined an anti-stigma program targeting mental health service providers at their agency offices with recruitment conducted via flyers through Maryland mental health facilities (N=133). Research participants reported their demographics which are summarized by group in Table 1. As expected, groups varied by age with college students being youngest; they were also far less likely to be married than the other groups. Only the group of mental health providers had more women than men: the other three groups contained more than 60% men. The groups varied by ethnicity, with the majority in two being European American, one being Asian/Asian American, and one being African American. Since the goal of this paper was to examine brief battery psychometrics, we posed no hypotheses herein about how these measures might differ by demographics or group, and we decided not to derive statistics testing questions about these kinds of differences in this paper.

Table 1
Demographic characteristics obtained from college students, community members, health care providers, and mental health providers.

	College students $N=35$	Community members $N=203$	Health care providers (HCP) $N=227$	Mental health providers (MHP) $N=133$
	$\bar{X}$(S.D.)/%	$\bar{X}$ (S.D.)/%	$\bar{X}$ (S.D.)/%	$\bar{X}$ (S.D.)/%
Sex				
Female	40	32	32	83.5
Male	60	68	68	16.5
Age	21.6 (3.2)	33.1 (7.4)	34.5 (6.1)	45.5 (11.4)
Ethnicity				
Asian/Pacific Islander	43	6.4	10.9	2.3
African American	11	6.9	7.8	36.1
European American	23	22.3	70.0	57.9
Native American	0	56.4	11.3	0.0
Multiple/other	23	7.9	0.0	3.8
Marital status				
Single/never married	83	23.2	8.4	27.8
Married	11	66	75.8	51.9
Long term relationship	6	5.9	9.3	6.0
Separated/divorced	0	4.9	4.4	12.0
Educational attainment				
Some high school	0	1.0	4.0	0.0
High school diploma	0	0.5	6.2	1.5
Associates degree	0	4.9	7.5	0.0
Some college	83	9.4	13.7	3.0
Undergraduate	23	72.4	64.3	3.0
Graduate	14	8.4	7.9	92.5
Did not specify	3	3.4	0.0	0.0

2.2. Measurements

Groups were administered the four measures of stigmatizing and affirming attitudes from the brief battery. Three of the four measures represented adaptations of existing measures of stigma, recovery, and personal empowerment which, if transposed unedited, added up to 96 Likert scale items. We explain our rationale for short forms under each scale.

2.2.1. Attribution Questionnaire-9

Public stigma was assessed using a short version of the 27-item Attribution Questionnaire (AQ-27) which has been used widely in stigma research (Halter, 2004; Hudes, 2007; Bastos-Turner, 2007; George-Concepcion, 2008; Kanter et al., 2008; Law et al., 2009; Brown, 2010). The AQ-27 comprises three items for each of the nine factors that emerged from path analyses of responsibility and dangerousness. For responsibility, factors represented blame, pity, danger, and help. For dangerousness, factors represent danger, fear, avoidance, coercion, and institutionalization. Items are posed in response to a brief vignette about Harry, "a 30 year-old, single man with schizophrenia." Research participants respond to individual items (e.g., "How dangerous would you feel Harry is?") on a nine-point Likert scale (9=very much). The AQ-9 was developed by selecting the single item that loaded most into each factor. Total AQ-9 scores range from nine to 81 with higher scores representing more stigmatizing views toward people with mental illness. Psychometrics for the AQ-9 are good and have been summarized elsewhere (Corrigan et al., 2006).

2.2.2. Recovery Assessment Scale

Affirming attitudes were assessed using adaptations of existing measures of recovery and empowerment, plus an instrument measuring self-determination

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