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From Stigma to Support: Evaluating Public Perceptions of Mental Health for Improved Healthcare Management

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Abstract

Background: Public perceptions of mental health play a critical role in shaping stigma, help-seeking behaviors, and societal support for individuals with mental health disorders. Despite increasing awareness, misconceptions and stigmatizing attitudes persist, necessitating updated assessments of contemporary attitudes. **Objective:** This study aimed to evaluate current public perceptions of mental health, focusing on stigma, functional capabilities of individuals with mental illness, and demographic differences in attitudes. **Methods:** A cross-sectional survey was conducted (N=196), analyzing responses using one-sample t-tests (neutral midpoint = 3), chi-square goodness-of-fit tests, independent samples t-tests (gender differences), and ANOVA (information source effects). **Findings:** Respondents strongly rejected overtly stigmatizing labels (e.g., "crazy," *p* < .001) but endorsed blame attribution (*M* diff = +1.107, *p* < .001). Most agreed that mental health problems often go undetected (86.2%) and can occur at any age (79.6%). No gender differences were found (*p* = .839), but perceptions varied significantly by information source (*F* = 3.00, *p* = .02), with formal education linked to more positive views than social media. **Conclusion:** While progress is evident in reducing explicit stigma, subtle misconceptions persist, particularly around personal responsibility for mental illness. Interventions should prioritize nuanced education, leveraging credible information sources to address enduring biases.

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Novelty: This study highlights the divergence between rejection of overt stigma and persistence of implicit biases, while identifying information sources as a modifiable factor shaping attitudes.

Keywords: mental health stigma, public perceptions, blame attribution, gender differences, information sources

Introduction

Mental health stigma remains the single greatest barrier to effective social inclusion and treatment of the mentally ill (Rodríguez-Rivas, et al., 2024). Despite decades of advocacy and public health campaigns, stigmatizing views and discriminatory practices remain dominant in societies worldwide (Walsh & Foster, 2021). Stigma is most frequently manifested in the notions that mentally ill people are dangerous, unpredictable, or responsible for their condition (Rodrigues & Queirós, 2025). These misperceptions not only perpetuate social exclusion but also create serious obstacles to seeking professional help, with many avoiding treatment for reasons of fear of judgment or discrimination (Franjić, 2024; Wagle, Neupane, Nyaupane, & Timalsena, 2024). The consequences of this stigma extend beyond personal suffering, contributing to system-level issues in the provision of healthcare and in workforce participation.

The pathogenesis of mental health stigma is complex, grounded on historical, cultural, and media accounts that have rendered mental illness over several decades as something bad and sensationalized (Voelker, 2024). Mental health conditions have been explained in the past in terms of personal weakness (Rapp & Goscha, 2011) or moral failing, impacts that persist to the present day, in spite of the progress in scientific understanding of mental illness as a medical condition. Media depictions have the propensity to fuel stereotypes through imbalance in linking mental illness to violence or instability (Spruce, 2023), even when evidence exists to prove that mentally ill individuals are more likely to be victimized than engage in acts of violence. Such deep-seated prejudices are then exacerbated by a systemic absence of mental health literacy (Qasim, 2024), rendering most people ill-equipped with knowledge to counteract stigmatizing assumptions.

In healthcare systems, stigma creates unique challenges that affect both service delivery and patients' outcomes. Research has shown that healthcare providers themselves may have implicit biases (FitzGerald & Hurst, 2017), leading to gaps in the quality of care received by individuals with mental illness. Underfunded mental health care and insurance disparities, expressions of structural stigma, are additional barriers to access to timely and appropriate treatment. In addition, internalized stigma in people with mental illness can result in self-discrimination (Fernández, Grandón, Vladimir-Vielma, Peñate, & Díaz-Pérez, 2023), where they internalize negative social perceptions and hold them against themselves, leading to delayed seeking of help and poorer

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treatment compliance. These complex problems can be dealt with by having a solid grasp of how stigma functions on the levels of individuals, interpersonal relationships, and institutions.

In the last few years, there has been increasing acknowledgment of the necessity to fight mental health stigma using specific interventions and policy change (Rodríguez-Rivas, et al., 2024). Public health campaigns, workplace mental health programs, and school-based anti-stigma programs have all improved in the task of modifying public attitudes. However, the persistence of some stereotypes, most specifically those of blame and dangerousness, suggests that more subtle approaches are needed. Analysis of prevailing public opinion is necessary for the formulation of effective interventions which not only counter explicitly stigmatizing assumptions but also challenge underlying and deeply ingrained prejudices. This study contributes to this effort by introducing the most recent information about modern attitudes, laying the groundwork for evidence-based practice and policy in public health advocacy and healthcare management.

Problem Statement

While prior literature has documented stigma of mental health, it is insufficient in describing how modern attitudes on different dimensions—blame attribution, dangerousness stereotypes, labeling—vary and which demographic variables (e.g., gender, sources of mental health information) influence these perceptions. In addition, conflicting trends (e.g., avoiding overtly stigmatizing language but maintenance of subtlety of bias) suggest the need for newer assessments to inform healthcare policy and awareness programs. Otherwise, interventions would fail to reach the fundamental misconceptions, and hence their effectiveness in stigma reduction and improvement in mental health outcomes will be limited.

Significance of the Study

The study contributes to healthcare administration and public health by

Identifying Enduring Stigmas: Determining which misconceptions (e.g., blame, dangerousness) continue to be common in the face of heightened mental health advocacy.

Informing Targeted Interventions: Supplying evidence for healthcare managers and policymakers to create education campaigns that are specific to certain biases (e.g., how to address blame attribution versus labeling stigma differently).

Highlighting Demographic Influences: Investigating whether gender or information sources (e.g., social media versus formal education) influence perceptions, enabling more tailored public health intervention.

Informing Policy Development: Offering evidence-based results to inform policy and development of workplace mental health initiatives and anti-stigma.

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Objectives

The study aims to:

- Assess current public attitudes towards mental health stigma, in terms of blame, dangerousness, and labeling.
- Explore gender differences in perceptions and primary sources of information for mental health.
- Examine the health service management and anti-stigma intervention implications of results.

This research bridges the gap between effective healthcare interventions and public opinion analysis so that stigma reduction campaigns are not only evidence-based but also well implemented.

Methodology

The study employed a cross-sectional survey design to assess public attitudes toward mental health stigma. The survey was completed by 196 participants, collecting attitudes through 5-point Likert-scale items (e.g., stigmatizing attitude endorsement) and demographic variables (e.g., gender, primary mental health source of information). The survey included validated blame attribution, danger-ousness stereotypes, and labeling scales, plus questions addressing mental health awareness (e.g., undiagnosed prevalence, age-related onset). Data were examined through one-sample t-tests (neutral midpoint = 3) to test departures from neutral attitudes, chi-square goodness-of-fit tests to identify response distributions for capacity stereotypes (e.g., employability, friendliness), and independent samples t-tests/ANOVA to test gender and information-source differences. Assumptions (e.g., homogeneity of variance through Levene's test) were tested for parametric tests.

For strength, effect sizes (e.g., mean differences, confidence intervals) and post-hoc tests (e.g., Tukey HSD for ANOVA) were computed. Expected cell frequencies (>5) were verified by chi-square tests, and listwise missing data were dropped. Quantitative analysis was conducted in SPSS with an alpha level of *p* < .05. The design favored generalizability by representative sampling and reliability by standardized measures, connecting findings to healthcare management goals by controlling for actionable stigma patterns (e.g., blame attribution vs. label rejection) and demographic moderators (e.g., information sources) to support targeted intervention.

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Results and Analysis

Table 1:One-Sample Test

	Test Value = 3					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
People with mental health problems are likely to blamed for their own conditions	16.863	195	.000	1.107	.98	1.24
People with mental illnesses are commonly dangerous	-5.861	195	.000	-.408	-.55	-.27
People with mental health disorder should be called crazy or Psyco	-53.119	195	.000	-1.832	-1.90	-1.76

The result of one-sample t-tests shows significant deviations from the neutral midpoint (Test Value = 3) for all three statements regarding stigma. In the first statement, "People with mental health problems are likely to be blamed for their own conditions," strong agreement on the part of respondents is evidenced by the positive mean difference of 1.107 ($t = 16.863$, $p < .001$). The 95% confidence interval (.98 to 1.24) also validates that this agreement is statistically significant and consistent throughout the sample. This indicates that a widespread stigma prevails wherein people with mental illness are considered personally responsible for their illness, indicating a need for public education aimed at refuting such a misconception.

For the second item, "People with mental illnesses are generally dangerous," the negative mean difference of -0.408 ($t = -5.861$, $p < .001$) suggests that, on average, informants dissented from this myth. The 95% confidence interval (-.55 to -.27) also suggests that the dissent is statistically significant, even though the smaller effect size compared to the first item suggests that while dangerousness mythology is being negated, some remaining bias still exists. This finding is appreciated, as it reflects improvement in eliminating harmful stereotypes, but further awareness campaigns would maybe solidify this positive trend.

The third statement, "People with mental health disorders should be called crazy or psycho," elicited most disagreement, with a mean difference of -1.832 ($t = -53.119$, $p < .001$) and a narrow 95% confidence interval (-1.90 to -1.76). This general rejection of stigmatizing labels reflects widespread societal disapproval of such stigmatizing language. The result attests to a positive shift

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in attitudes, perhaps due to increased mental health advocacy and education. However, the continued presence of blame attribution (first statement) with this finding suggests that while overtly offensive language is rejected by society, more subtle forms of stigmatizing behavior such as blaming the patients for their conditions still require explicit intervention. Taken together, these results indicate both progress and ongoing challenges in public attitudes towards mental health.

Table 2: Test Statistics

	People having mental health disorder are 2t capable of friendship	People having mental disorder can work
Chi-Square	88.235[a]	137.418[a]
df	4	4
Asymp. Sig.	.000	.000

a. 0 cells (0.0%) have expected frequencies less than 5. The minimum expected cell frequency is 39.2.

The Chi-Square Goodness-of-Fit test findings are very significant for both of the statements in regard to people's attitudes towards individuals with mental health disorders. For the statement "People having mental health disorder are not capable of friendship," the Chi-Square statistic value of 88.235 ($df = 4$, $p < .001$) indicates that the responses of the respondents were significantly different from a uniform distribution. This suggests a strong disagreement with the view that individuals with mental illness are unfriendly, since the frequency of responses observed was very different from what would be expected under the condition of opinions being equally distributed. The fact that none of the expected frequencies is below 5 (minimum expected cell frequency = 39.2) ensures this result is robust, validating the evidence of rejection of this stereotype being widespread and statistically significant.

Similarly, for the statement "People with mental disorder can work," the larger Chi-Square value of 137.418 ($df = 4$, $p < .001$) demonstrates an even larger divergence from an equalized distribution. This represents virtual consensus that individuals who are afflicted with mental illness can work, with answers heavily skewed in a positive direction. The extremely low p-value ($p < .001$) and the absence of small expected cell frequencies also attest to the robustness of this result. These combined outcomes indicate a progressive shift in societal attitudes, away from archaic stereotypes regarding the social and work ability of those with mental health issues. However, the dramatic contradiction with these results and earlier blame attribution data (from t-test) suggests that while functional capacities are better recognized, there can be more profound stigmas about personal responsibility for mental illness that require specified interventions.

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Table 3: Many People have mental health problem but they do not realize it

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	1	.5	.5	.5
	Disagree	4	2.0	2.0	2.6
	Neutral	22	11.2	11.2	13.8
	Agree	122	62.2	62.2	76.0
	Strongly Agree	47	24.0	24.0	100.0
	Total	196	100.0	100.0	

The frequency data indicate that the overwhelming majority of the sample (86.2% in total) agree or strongly agree with the statement "Many people have mental health problems but do not realize it," 62.2% agreeing and 24.0% strongly agreeing. Only 2.5% disagree or strongly disagree, and 11.2% neither agree nor disagree. This high agreement rate reflects cross-the-board comprehension among the respondents that mental illness often goes undiagnosed, reflecting an overarching need for enhanced mental health awareness and early detection in society. The low disagreement rate (a mere 2.5%) also reflects the near-universal acceptance of this concept among the sample population.

Table 4: Mental illness can occur at most any age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	1	.5	.5	.5
	Disagree	7	3.6	3.6	4.1
	Neutral	32	16.3	16.3	20.4
	Agree	102	52.0	52.0	72.4
	Strongly Agree	54	27.6	27.6	100.0
	Total	196	100.0	100.0	

The frequency distribution shows that 79.6% of the respondents are in agreement or in strong agreement that "Mental illness can occur at almost any age," 52.0% agreeing and 27.6% strongly agreeing, which demonstrates overwhelming agreement on the age-neutrality of mental health conditions. A paltry 4.1% of them disagree or strongly disagree, and 16.3% neither agree nor disagree, showing although most recognize mental illness as not age-specific, there remains some portion of the population that can be taught about this sphere of mental health knowledge.

The results of the survey indicate widespread public awareness of major determinants of mental health, with 86.2% agreeing that there are undiagnosed mental health problems in most individuals and 79.6% agreeing that mental illness can emerge at any age. While both postulates were greeted with overwhelming consensus (62.2% and 52.0% respectively) and great strong consensus (24.0%

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and 27.6%), there was a minority of opposition (2.5% and 4.1%) or neutrality (11.2% and 16.3%), suggesting the majority of participants do have an understanding of these fundamental principles of mental health, though there are still areas that might be served by targeted education campaigns. Overall, the results indicate adequate baseline knowledge of mental health disorder prevalence and age distribution in the population sampled.

Table 5: Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
percepcion_mean	Equal variances assumed	2.162	.143	-.203	194	.839	-.01077	.05295	-.11519	.09366
	Equal variances not assumed			-.215	190.744	.830	-.01077	.05001	-.10941	.08787

The independent samples t-test was conducted to examine potential gender differences in perceptions of mental health disorders, with male (N=78) and female (N=118) respondents showing nearly identical mean scores (Male: M=3.118, SD=0.300; Female: M=3.129, SD=0.399). Levene's test for equality of variances (F=2.162, p=.143) indicated no significant difference in variance between groups, suggesting the assumption of homogeneity of variance was met. The t-test results revealed no statistically significant gender difference in mental health perceptions (t(194)=-.203, p=.839), with a negligible mean difference of -.011 and a 95% confidence interval spanning from -.115 to .094, which includes zero. These findings suggest that, on average, men and women in this sample hold remarkably similar attitudes toward mental health issues.

These results have important implications for mental health awareness campaigns, suggesting that educational interventions may not need to be gender-specific when addressing general perceptions of mental health disorders. The finding that both genders share similar baseline perceptions could indicate either successful previous efforts to equalize mental health understanding across genders or perhaps that the specific aspects of mental health measured in this study are equally salient to both men and women. However, researchers should note that this analysis examines only overall

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perception means and does not rule out potential gender differences in specific aspects of mental health stigma or awareness that might emerge in more granular analyses of individual survey items. Future research could explore whether these gender similarities persist across different cultural contexts or age groups.

Table 6: ANOVA

percepcion_mean

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	1.510	4	.377	3.000	.020
Within Groups	24.034	191	.126		
Total	25.544	195			

The ANOVA finding confirms the variations as significant statistically ($F(4,191)=3.00$, $p=0.02$) and that perceptions are significantly influenced by where they received their mental health information. The variance between groups (Mean Square=0.38) was larger than the variance within groups (Mean Square=0.13) and facilitates the application of additional post-hoc tests (e.g., Tukey HSD) to specify which specific sources differ. For instance, the higher mean for formal education relative to social media suggests that systematic schooling may construct more precise or less stigmatized mental health conceptions than loose online content. Such findings underscore the importance of information-source-specific mental health messaging.

Conclusion

The findings show a highly rich and complex profile of public opinion about mental health with both progress and current difficulties. While there is strong rejection of very stigmatizing labels (e.g., "crazy" or "psycho") and widespread recognition of the functional capacities of mentally ill individuals, harmful misconceptions (e.g., blaming the individual for the disorder) still persist. The widespread agreement that mental illnesses typically do not get discovered and can occur at any age suggests strong baseline knowledge, even if purpose-specific training might be useful to disagreeing or neutral minorities. Significantly, no gender gap was seen in overall views, suggesting universal solutions may suffice for broad awareness campaigns. However, the significant variance in attitudes by information sources (for example, social media versus educational institutions) identifies the need for targeted messaging to address imbalances in knowledge. Overall, this evidence identifies the ongoing need for muted efforts at stigma reduction, paired with strong encouragement of accurate, unbiased mental health information in every population.

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