Economic System Justification Predicts Stigmatization of Mental Illness in the United States

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Abstract

Mental illness stigma remains persistent despite prominent public campaigns to combat it. We propose that system justification theory, which posits that people are motivated to see current institutions and arrangements as fair and legitimate, can help explain the near-universal stigmatization of mental illness. To investigate system justification and mental illness stigma, we conducted three studies comprising survey and experimental methods (Total N = 1,514). In two surveys, including a nationally representative survey of US adults, the tendency to view the current economic system as fair and legitimate was the strongest and most consistent unique predictor of stigmatizing responses across a wide range of measures. In an experiment, we manipulated the economic positioning of vignette characters meeting the diagnostic criteria for depression and social phobia. Participants' responses were more stigmatizing when the character's position in the economic system was low (vs. high), operationalized in terms of income. The findings support previous suggestions that system-justifying beliefs are relevant for mental illness stigma and indicate that reactions to mental illness are usefully seen in light of attitudes toward the social and economic system.

Keywords: System justification, mental illness, stigma, socio-economic status

Public Significance Statement: This study found that beliefs about the economic system are associated with how people react to individuals with mental illness. People who believe that the capitalist system in the U.S. is fair and just are more likely than others to react negatively to individuals with a condition such as depression and anxiety.

As much as one might wish that tolerance toward people with mental illness would have improved over the past several decades, the social position of those who suffer from mental illness remains fundamentally disadvantaged (Pescosolido et al., 2021). The stigmatization (and self-stigmatization)[1] of mental illness persists despite repeated efforts to combat it (Evans-Lacko et al., 2012; Hinshaw & Stier, 2008; Link & Phelan, 2001).

Definitions of social stigma vary because the phenomenon is complex. Hinshaw and Stier (2008, p. 368) define the process of stigmatization as involving stereotyping, prejudice, and discrimination, that is: (a) "cognitive labels that characterize members of devalued groups in blanket terms"; (b) "negatively toned affect that often emerges toward such individuals"; and (c) "the curtailing of rights and life opportunities." Because stigmatizing processes can affect so many aspects of people's lives, including earnings, housing, and health outcomes (Link & Phelan, 2001), social scientists agree that the pernicious effects of stigma can be as detrimental to the individual as the mental illness itself (e.g., Hinshaw & Stier, 2008).

The primary approach in Western societies has been to address stigma through public awareness campaigns that have emphasized biomedical understandings of mental illness, suggesting they are "like any other" illnesses. Their success has been modest at best (Corrigan, 2018). Despite public campaigning, the societal rejection of individuals with severe mental illness has increased rather than decreased (Angermeyer & Matschinger, 2005; Pescosolido et al., 2010, 2021).

The problem is not that public beliefs about mental illness are completely unchangeable. According to data from the General Social Survey, campaigns by

[1] Evans-Lacko et al. (2012) defined self-stigma as "a process in which a person with a mental illness applies and internalizes stigmatizing attitudes and beliefs held by the public" (p. 1741) and noted that it has been empirically linked to lower self-efficacy, poorer functioning, lower levels of treatment-seeking, and higher rates of hospitalization.

pharmaceutical companies and the American Psychiatric Association were highly successful in changing beliefs about mental illness. In 1996, slightly more than half of U.S. adults believed that mental illnesses such as schizophrenia, major depression, and alcohol dependence are caused by chemical imbalances in the brain. A decade later, the percentage had risen to two-thirds (Pescosolido et al., 2010), despite the fact that there has never been rigorous scientific evidence to support the claim (e.g., Moncrieff et al., 2023). In any case, this increase in the belief that mental illness is caused by chemical imbalances failed to reduce stigma. According to Pescosolido and colleagues (2010, p. 1325), "stigma among the American public appears to be surprisingly fixed, even in the face of anticipated advances in public knowledge." Although there has been some improvement in attitudes towards depression in recent years, stigmatization of conditions such as schizophrenia has worsened at the same time (Pescosolido et al., 2021).

In this article, we provide new evidence that might help to explain why mental illness stigma remains pervasive. We draw largely on system justification theory (Jost, 2020), and the concept of economic system justification in particular (Goudarzi et al., 2020) to understand how, when, and why people blame individuals for their misfortune, rather than economic or political systems and institutions. In three studies, including a nationally representative sample from the U.S., we investigate the hypotheses that (a) ideological justification of the economic system is associated with stigmatizing attitudes towards individuals with mental illness, and (b) individuals with mental illness who are seen as economically unsuccessful are more likely to be stigmatized than economically successful individuals, even when their symptoms and work status are identical.

Individual-, Group- and System-Level Processes in Stigmatization

Ever since Erving Goffman's (1963) influential work, the stigmatization of mental illness has been understood to operate at the level of the individual and the social group. That

is, individuals frequently subscribe to group stereotypes about people with various types of mental illness as being unpredictable and dangerous (Crisp et al., 2000; Hinshaw & Stier, 2008; Jones & Corrigan, 2014; Ottati et al., 2005). Perceptions of personal responsibility, controllability, and social desirability have been proposed to explain why some conditions are more stigmatized than others (Krendl & Freeman, 2019; Phalen et al., 2019). In terms of perceiver characteristics, people with personal experiences of mental illness—their own experiences or those of friends and family members—have less negative reactions than people who do not (Angermeyer & Matschinger, 1996; DeLuca & Yanos, 2016).

While these are important aspects of the problem, mental illness stigma cannot be understood outside of the broader context of social, economic, and political arrangements in which it occurs (Hatzenbuehler & Link, 2014). Stigmatization operates in contexts of social inequality (Hinshaw & Stier, 2008), and the mental health system itself is deeply embedded in social, economic, and political institutions that are rife with inequality (Burns, 2015). Although sociologists, historians, and philosophers have long recognized the importance of social and economic power in the context of mental illness (e.g., Foucault, 1965; Scull, 1993), it has not been a priority in psychiatric or psychological research.

A complementary perspective that may be useful for understanding stigma comes from system justification theory. System justification theory posits that people are psychologically motivated to view existing social institutions and arrangements as fair, legitimate, and desirable (Jost, 2020). According to the theory, people have a psychological tendency to legitimize and bolster the social, economic, and political systems on which they depend, including those that give rise to social and economic inequality. System justification theory is by now supported by a substantial body of empirical evidence (Jost, 2020, 2021).

Stigmatization from the Perspective of System Justification Theory

Several authors have proposed that system justification theory could be useful for

explaining both the pervasiveness of mental illness stigma and the forms it takes. For example, Watson and colleagues (2003) argued that people embrace the negative stereotype that individuals with mental illness are dangerous not because they see evidence for it in their own lives, but for motivated reasons that help to justify the social exclusion and deprivation of those seen as mentally ill (see also Jones & Corrigan, 2014). To our knowledge, system justification theory has not been directly applied to the study of stigmatization of mental illness in the U.S., but the idea that system-justifying motives play a role in such stigmatization is indirectly supported by empirical research investigating other related ideological beliefs, opinions, and values.

For example, individual differences in the "belief in a just world"—defined as the presupposition that "people get what they deserve and deserve what they get" (Lerner, 1980)— predict negative attitudes and social distancing toward people with mental illness (Bizer et al., 2012). Likewise, the meritocratic assumption that anyone who works hard in the U.S. can succeed financially—and that people are therefore personally responsible for their own social and economic outcomes—is associated with the stigmatization (and self-stigmatization) of people with mental illness (Rüsch et al., 2010). Self-identified political conservatism, which is closely linked to system-justifying beliefs (Jost, 2020, 2021), is also correlated with negative attitudes toward individuals with mental illness (Phelan & Link, 2004), as is right-wing authoritarianism (DeLuca & Yanos, 2016; DeLuca et al., 2018; Gonzales, 2022; Szabó et al., 2024)—measured in terms of submission to authority figures, adherence to traditional conventions, and scapegoating of deviants (Altemeyer, 2006). According to Jost and Hunyady (2005), what these various and sundry beliefs and belief systems appear to have in common is that they "serve a similar ideological function, namely to legitimize existing social arrangements" (p. 261).

In this research program, we investigated mental illness stigma from the perspective

of system justification theory. In addition to motivated beliefs about the diffuse social system, we hypothesized that beliefs and ideologies pertaining to the economic system would be especially important for understanding stigmatizing responses to mental illness. In most cases, people who score higher on Kay and Jost's (2003) general system justification scale, which focuses on the U.S. social system overall, also tend to score higher on Jost and Thompson's (2000) economic system justification (ESJ) scale, which focuses on the capitalist economic system in particular. In a large, nationally representative sample of Americans, the correlation between these two variables was .33 (Jost, 2019, pp. 295-296). At the same time, it is possible for the two types of system justification to diverge (e.g., see Azevedo et al., 2017), and this could be the case with regard to attitudes about mental illness.

Several studies cited above focused on right-wing authoritarianism, suggesting that people with mental illness are perceived as "personally irresponsible" or "deviant" and therefore castigated by authoritarian conservatives. This correlation appears to be robust, so it seemed unnecessary to replicate it. Instead, we advanced a complementary hypothesis, namely that people with mental illness may be regarded as "unproductive" (Pescosolido et al., 2013) or failing to "contribute to society" (Reinhart, 2025)—that is, falling short of cultural expectations about self-sufficiency and economic productivity in capitalist societies. This was a primary reason for focusing primarily on economic system justification (Goudarzi et al., 2020; Jost & Thompson, 2000), rather right-wing authoritarianism (Altemeyer, 2006) or general system justification (Kay & Jost, 2003). Furthermore, to the extent that people suffering from mental illness are seen as woefully neglected by society or emblematic of deficiencies in the system, they may pose a potential threat to the legitimacy of the socio-economic system. In such situations, victim-blaming (rather than system-blaming) is a fairly typical response (e.g., Jost, 2020; Lerner, 1980).

The Role of Economic System Justification

We hypothesized that system-defensive beliefs and ideologies related to current economic institutions and arrangements would play a significant and underappreciated role in mental illness stigmatization. Our reasoning was based on several premises. One is that in the U.S. and other capitalist societies, which prize economic productivity and individuals with exceptional financial means, any personal characteristic that could be seen as compromising an individual's economic capability will lower one's social standing. An individual suffering from mental health challenges may be seen (correctly or incorrectly) as especially unlikely to be economically productive and/or likely to become an economic burden on others. Consistent with this line of thinking, previous research has found that high (vs. low) economic system-justifiers are less emotionally troubled by the suffering of homeless people, apparently because they blame homeless people for their plight, thereby escaping feelings of social injustice (Goudarzi et al., 2020).

Another possibility is that both poverty and mental illness invite essentialist biases. Psychological essentialism is the lay tendency to assume that members of a given category share an underlying, unobservable essence that explains their membership in the category (Gelman, 2003; Haslam & Kvaale, 2015). When essentialist thinking is recruited, underlying essences are assumed to be immutable, fundamental, and natural (Dar-Nimrod & Heine, 2011). This is particularly unfounded in the case of mental illness, because current diagnostic categories neither pick out natural kinds (Kincaid & Sullivan, 2023) nor reflect any identified biological or etiological mechanisms (Allsopp et al., 2019; Hyman, 2010). Despite—and because of—their scientific limitations, DSM categories of mental illness are known to create common "epistemic blind spots" by becoming "literalized" (Fried, 2022), or reified, through their use (Hyman, 2010), and by being erroneously interpreted as causal explanations (Kajanoja & Valtonen, 2024), thereby reinforcing essentialist biases. Essentialist thinking is associated with social stereotyping, including stereotyping of people with mental illness

(Hantzi et al., 2019; Haslam & Kvaale, 2015), as well as the endorsement of conservative, system-justifying beliefs (Keller, 2005).

There are probably other reasons, in addition to victim blaming and essentialist thinking, why attitudes about the fairness and legitimacy of the capitalist economy would be tied to mental health stigmatization. For example, the construction of diagnostic categories used to categorize people as mentally ill, the delivery of treatments, and the building of the evidence base informing diagnosis and treatment are shaped by the financial and guild interests of the pharmaceutical industry and the psychiatric profession (e.g., Moncrieff, 2006, 2022; Whitaker & Cosgrove, 2015). In addition, policymakers often favor individualized biomedical solutions as a way of transforming complicated social problems into sheerly technical ones, which can be a way of maintaining the status quo and resisting costly social, economic, and political reforms (e.g., Chater & Loewenstein, 2023). Thus, if ideological justification of the economic system operates as a form of motivated social cognition that helps to legitimize the suffering of certain individuals and to downplay or ignore social-structural factors maintaining inequality, there are a variety of routes such rationalizations can take (Jost, 2020). For all of the above reasons, we investigated the role of economic system justification, in addition to general system justification, in the stigmatization of mental illness.

Transparency and Openness

The data and codebooks for all studies have been made publicly available on the OSF website: https://osf.io/yz2e6/?view_only=e577ab9883084e44a842f071154d3f06 . These studies were not preregistered. We report all data exclusions, all manipulations, and all measures in the studies. Sample sizes were determined according to practical and financial considerations. No *a priori* data collection power calculations were conducted.

Study 1

To investigate the role of system-justifying beliefs in the stigmatization of mental illness, we conducted an online survey. Because the role of system justification had not been directly investigated in the context of mental illness in the U.S. before—and prior research has used an extremely broad array of instruments to assess mental illness stigma, with various strengths and weaknesses (Link et al., 2004)—we administered a wide range of measures to determine which, if any, aspects of political ideology and system justification would be relevant, and to explore their consistency across measures. To this end, we asked participants about their beliefs, attitudes, and behavioral intentions with respect to individuals with mental illness as well as their ideological beliefs, including political orientation and both general and economic forms of system justification. We also asked about their beliefs in genetic determinism because these and other biomedical causal beliefs have been linked to system justification, stereotyping, out-group prejudice, and other beliefs about people with mental illness (Keller, 2005; Kvaale & Haslam, 2016). Finally, because previous research has found that personal experiences affect attitudes about mental illness (Angermeyer & Matschinger, 1996; DeLuca & Yanos, 2016), we asked participants about their own mental health experiences and adjusted for these in multivariate analyses.

Method

Participants

Four hundred U.S. participants were recruited on Amazon's Mechanical Turk platform and paid $2.50. Thirty-one participants were excluded for failing to pass the attention check (see Measures). One more participant was excluded because she reported having confused the direction of the response scale for several questions. The final analytic sample was comprised of 368 participants (mean age 36.0; range 19-73; 57.3% female). Their racial/ethnic breakdown was 78.8% white, 6.0% Black/African-American, 7.3% Hispanic/Latinx, 3.5% Asian, and 2.7% multiracial. The modal level of education was a

bachelor's degree; 53.5% and 17.7% were working full- and part-time, respectively, and 6.5% were students. The median family income in the previous year was $50,000-$74,999.

Procedure and Materials

In addition to mental illness questionnaires, the survey included items related to political ideology, system justification, genetic determinism, and demographics. The mental illness and political (including SJT) items were presented in two main blocks in a predetermined order, with the presentation order of the two blocks randomized for each participant. Afterward, participants were asked about genetic determinism and their own demographic characteristics. Halfway through the survey, an attention check item was administered. It was a multiple-choice question, seemingly inquiring about political activities. However, the question stated that we were interested only in whether participants took the time to read instructions, and they were simply asked to select the last response option. Participants were debriefed at the end of the study, which was approved by the New York University Institutional Review Board. The dataset (Valtonen et al., 2025) can be accessed here: https://osf.io/yz2e6/?view_only=e577ab9883084e44a842f071154d3f06.

Independent Variables

Political orientation. Participants located themselves on scales ranging from "extremely liberal" (1) to "extremely conservative" (5) in terms of (a) *social and cultural issues*, (b) *economic issues,* and (c) *political orientation overall*. Responses to the three questions were averaged for analyses (Cronbach's $\alpha = .91$).

General system justification. We administered the 8-item GSJ scale (Kay & Jost, 2003, see Appendix E), which includes items such as "In general, the American system operates as it should" and "Most policies serve the greater good" ($\alpha = .83$). For GSJ, ESJ, and BGD, participants indicated their agreement or disagreement using a scale ranging from 1= ("strongly agree") to 5 ("strongly disagree"). Responses were recoded so that higher

values indicate stronger endorsement of the statements.

Economic system justification. We administered the 17-item ESJ scale (Jost & Thompson, 2000. See Appendix E, Supplementary Online Materials, SOM), which includes items such as "Economic positions are legitimate reflections of people's achievements" and "Most people who don't get ahead in our society should not blame the system; they have only themselves to blame" (α = .87).

Beliefs about genetic determinism. We administered 10 items from Keller's (2005) BGD scale, including: "In my view, many forms of human behavior are biologically determined and can therefore be seen as instinctual" and "I think the chief reason why parents and children are so alike in behavior and character is that they possess a shared genetic inheritance" (α = .80).

Personal experiences. Participants were also asked to respond yes or no to the following question and to elaborate if they wished: "Do you have personal experience of mental health services?" More than one-third (36.7%) answered yes, and more than half (57.6%) stated that either a family member or close friend had experienced mental illness.

Dependent Variables

Negative stereotypes and recovery beliefs. Following DeLuca and Yanos (2016), we selected 7 items with the highest factor loadings from the "Attitudes Toward Mental Illness Scale" developed by Kobau and colleagues (2010). Three items were about negative stereotypes of mentally ill people as dangerous, unpredictable, and "hard to talk with" (α = .71). Four items were about recovery beliefs (e.g., whether people with mental illness can eventually recover and lead normal lives; α = .89). Responses for all dependent variables were provided on a scale from 1 to 5, with higher scores recoded to reflect greater endorsement of negative stereotypes, recovery beliefs, and behavioral intentions.

Behavioral intentions. We administered Evans-Lacko et al.'s (2011) 4-item

"Reported and Intended Behavior Scale," which is a measure of social distance. Participants first read: "The term 'mental illness' may refer to diagnoses such as schizophrenia, bipolar disorder, major depressive disorder, posttraumatic stress disorder (PTSD), panic disorder and others." They were then asked whether they would be willing to live with, work with, live near, and be friends with a person who had a mental health problem ($\alpha = .91$).

Community attitudes towards the mentally ill. We administered the 40-item "CAMI" scale developed by Taylor and Dear (1981), which has been considered the "gold standard" for measuring stigma (Bernadàs et al., 2022). It is comprised of four subscales measured with 10 items each, namely "Authoritarianism" (e.g., "Mental patients need the same kind of control and discipline as a young child"; $\alpha = .85$); "Benevolence" (e.g., "We need to adopt a far more tolerant attitude toward the mentally ill in our society," reverse-scored; $\alpha = .91$); "Social restrictiveness" (e.g., "Anyone with a history of mental problems should be excluded from taking public office"; $\alpha = .90$); and "Community mental health ideology" (e.g., "Residents should accept the location of mental health facilities in their neighborhood to serve the needs of the local community," reverse-scored; $\alpha = .92$).[2]

Analyses

To estimate the relative contributions of various independent variables, we conducted hierarchical linear regression analyses. Our main variables were personal experiences with mental illness, political orientation, belief in genetic determinism, general system justification (GSJ), and economic system justification (ESJ). All demographic variables (age, sex, race, education, and family income)[3] were entered in the first step (Model 1), personal experiences

[2] We also administered case vignettes and diagnosis-specific questions to enhance the generalizability of our results. Because of space constraints and the fact that results were highly convergent across measures, descriptions of those variables and analyses were relegated to the Supplementary Online Materials, SOM (Appendix A).

[3] Sex was coded as 0 = not female, 1 = female; race as 0 = not white, 1 = white; and personal experience with mental illness as 0 = no 1 = yes. Education and family income were coded using 8-point scales (1 = "12th grade/less," 2 = "high school diploma/equivalent," 3 = "some college, no degree," 4 = "Associate

in the second (Model 2), belief in genetic determinism, political orientation, and GSJ in the third (Model 3), and ESJ in the last step (Model 4), along with all variables from earlier steps.

Results

Descriptive statistics, including bivariate correlations, are presented in Table S1 (SOM). Personal experience of mental health services, political orientation, and system-justifying beliefs were all correlated with perceptions of mental illness as expected. Personal experience was correlated with less negative perceptions and more tolerant attitudes, whereas political conservatism, GSJ, and ESJ were associated with more negative reactions, with the strongest correlations emerging for ESJ. The same was true for all four dimensions of the "Community Attitudes towards the Mentally Ill" Scale, with the strongest correlations again observed for ESJ. Somewhat surprisingly, belief in genetic determinism was either weakly correlated or uncorrelated with perceptions of mental illness on most measures.

The results of hierarchical regression models are summarized in Tables 1 and 2. Relative to other ideological beliefs, ESJ clearly emerged as the best unique predictor of negative responses toward individuals with mental illness across measures, even after adjusting for demographic and other independent variables. Adding belief in genetic determinism, political orientation, and GSJ (Model 3) and ESJ (Model 4) significantly increased the amount of variance explained on all measures of attitudes toward people with mental illness. However, political conservatism and GSJ no longer accounted for unique variance once ESJ was entered into the same model. Because conservatism, GSJ, and ESJ were intercorrelated, we tested for multicollinearity but found no grounds for concern (tolerance = .63, VIF = 1.59; tolerance = .62, VIF = 1.63; tolerance = .50, VIF = 2.01, respectively).

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degree," 5 = "Bachelor's degree," 6 = "Master's degree," 7 = "Professional degree (e.g., MD, JD)," 8 = "Doctorate degree," and 1 = $0-$14,999, 2=$15,000-24,999, 3 = $25,000-49,999, 4 = $50,000-74,999, 5 = $75,000-$99,999, 6 = $100,000-$149,999, 7 = $150,000-$199,999, 8 = over $200,000, respectively).

As shown in Tables 1 and 2, ESJ was the best unique predictor of negative stereotypes (β = .27, p < .001); pessimistic recovery beliefs (β = -.47, p < .001); intolerant behavioral intentions (β = -.37, p < .001); authoritarianism (β = .38, p < .001); lower benevolence (β = -.49, p < .001); social restrictiveness (β = .38, p < .001); and lower mental health community ideology (β = -.39, p < .001). On some measures, adding ESJ increased the amount of explained variance by nearly twofold (e.g., benevolence)—or even more (e.g., pessimistic recovery beliefs).

Personal experience was associated with less stigmatizing responses across various measures. Belief in genetic determinism was rarely a significant unique predictor; it was associated with recovery beliefs and benevolence in mental health attitudes, but only weakly, especially when compared to the effects of ESJ. Because our goals in Study 1 were largely exploratory, we administered a wide range of measures. Results were highly comparable for most measures of stigmatization, including responses to diagnosis-specific questions and individual vignettes (see SOM, Appendix A). Because we conducted multiple comparisons, there is the possibility of an inflated family-wise Type I error rate. On the basis of findings from the first study, we made more focused predictions in subsequent studies.

Discussion

Across a wide range of measures, including negative stereotypes, recovery beliefs, behavioral intentions, and community mental health attitudes, economic system justification emerged as the strongest and most unique and robust correlate of mental illness stigmatization. In a remarkably consistent pattern across quite different measures, ESJ predicted stigmatizing attitudes, beliefs, and behavioral intentions better than any other independent variable. While all measures of theoretical interest—political conservatism, general system justification, and economic system justification—were correlated with measures of stigma, hierarchical regression revealed that the relative contributions of political

orientation and GSJ were minor or non-significant once ESJ was included.

Consistent with prior studies, personal experience remained a significant correlate of mental health attitudes even when other variables were included in the model (Angermeyer & Matschinger, 1996). Belief in genetic determination was associated with stigmatizing responses on some measures, but the effects were much weaker than for ESJ. Belief in genetic determination failed to predict behavioral intentions, suggesting that it has relatively little to do with social distancing (but see Kvaale et al., 2013; Lebowitz & Appelbaum, 2019). For these reasons, we omitted belief in genetic determination from subsequent studies.

Study 2: A Nationally Representative Survey of U.S. Adults

Study 1 revealed that ESJ was associated with stigmatizing responses to mental illness, even after adjusting for many other factors. A clear limitation, however, is that the first study was based on a convenience sample. To increase the generalizability of our conclusions, we conducted a large-scale replication and extension using a nationally representative sample of Americans.

Method

Sample

We hired a research firm, Cint (www.cint.com), to survey a nationally representative sample of 1,028 Americans (52.3% women) from June 9 to July 8, 2023. Quotas were designed to match those of the 2018 U.S. Census Current Population Survey (CPS) on age, income, education, and gender, with a maximum difference of 5% at the bracket level. Sample representativeness is assessed in Table S7 (SOM), which shows an average absolute deviation of 3.9% points (*MD* = 4.55) from the desired quotas, confirming that the sample achieved a high level of national representativeness.

In addition to administering a greater variety of political and psychological instruments (including full scales) than in other nationally representative surveys (e.g.,

ANES, GSS, WVS), we took several steps to maximize data quality, taking recommended steps to address careless responding (Meade & Craig, 2012). We employed 12 random attention questions, 11 page-time controls, and a Captcha question. A total of 2,766 participants were directed to the survey, and 2,044 of them completed the survey (resulting in an attrition rate of 26%). There were 1,016 (37%) participants who failed more than two attention checks or finished the survey in under ~22 minutes and were therefore excluded. For the final analytic sample of 1,028, participants who completed all materials had a completion time of 75.22 minutes on average (*MD*: 63.24min).

The age distribution of the analytic sample was as follows: 18–24 years (12.26%), 25–34 (17.7%), 35–44 (16.54%), 45–54 (16.44%), 55–65 (16.05%), and older than 65 (21.01%). The ethnic breakdown was: White (75.19%), Black/African American (11.28%), Latinx (6.42%), Asian/Pacific Islander (4.57%), Native American (0.88%), Middle Eastern (0.29%), and "other" (1.36%). In terms of religion, 23.25% identified as Catholic, 39.88% as Protestant, 3.02% as Jewish, 1.95% as Muslim, 17.7% as either Atheist or Agnostic, and 14.2% were unsure or declined to answer. With respect to educational achievement, 38.33% attended high school, 28.79% attended college but did not graduate, and 32.88% received a bachelor's or graduate degree. The distribution of income was as follows: Less $15,000 (11.19%), $15,000 to $24,999 (9.53%), $25,000 to $34,999 (9.44%), $35,000 to $49,999 (13.04%), $50,000 to $74,999 (17.9%), $75,000 to $99,999 (12.74%), and $100,000 or more (26.17%). The median income category was $50,000 to $74,999.

Procedure and Materials

Independent variables. General and economic system justification were measured as in Study 1, but on a response scale from 1 ("strongly disagree") to 9 ("strongly agree"). For political orientation, respondents located themselves on a scale ranging from 0 ("strongly liberal") to 100 ("strongly conservative"). Because belief in genetic determinism was a weak

predictor of stigmatization in Study 1, we omitted it from Studies 2 and 3.

Dependent variables. Respondents used a scale from 1 ("strongly disagree") to 9 ("strongly agree") to answer questions pertaining to: (1) *Social tolerance*, consisting of two items pertaining to social distance (Link et al., 2004): "I would be willing to live next door to a person with mental illness"; and "I would be willing to make friends with someone with mental illness."[4] Responses were averaged for analyses, $r(1026) = .77$). (2) *Personal Blame* was assessed with this item: "A person with mental illness [severe depression] only has him/herself to blame" (Crisp et al., 2000). (3) *Negative stereotyping* was assessed with one item: "A person with mental illness is a danger to others" (DeLuca & Yanos, 2016; Kobau et al., 2010). (4) *Recovery pessimism* was assessed with this item: "A person with mental illness will not improve if given treatment and support" (DeLuca & Yanos, 2016; Kobau et al., 2010). (5) *Exclusionary sentiments* were assessed using two items modified from prior studies (Pescosolido et al., 2013; Phelan, 2005): "People with mental illness should be isolated from society," and "Persons with serious hereditary defects and mental disorders should be compulsorily sterilized." Responses were averaged for analyses, $r(1026) = .59$.

Analyses

As in Study 1, we conducted hierarchical linear regression analyses to examine whether system justification and conservatism were significant correlates of the stigmatization of mental illness and to estimate the relative contributions of various independent variables. As before, the main variables of theoretical interest were GSJ, ESJ,

[4] Half of the participants were asked about "mental illness" in general, and the other half about "severe depression." In theory, this would have enabled us to compare results based on these two subcategories. However, the results suggest otherwise. One item (about compulsory sterilization) was presented in identical form to all participants, which provided an opportunity to assess split-half reliability. While the results were generally quite similar across the two wording conditions (see Table S9, SOM), responses to the compulsory sterilization item differed between the two half samples despite identical wording, $F(1,1026) = 5.74$, $p = .017$. Reasons for this are unclear, but the split-half difference is unexpected and suggests that comparisons between half-samples may be unreliable. In the text, we therefore present the results collapsed across the two versions of the questionnaire. Descriptive statistics and hierarchical regression models are presented separately for the two subcategories in the SOM (Tables S9-S12).

and political orientation. Demographic variables were entered in the first step (Model 1),[5] political orientation and GSJ in the second (Model 2), and ESJ in the third and final step (Model 3), along with all independent variables from earlier steps. To adjust for multiple comparisons across measures, we used a Bonferroni-corrected alpha level for significance (i.e., $\alpha = .01$ to account for separate analyses for five different dependent measures).

Results

Descriptive statistics, including bivariate correlations, are provided in Table S8 (SOM). The results of hierarchical regression analyses, summarized in Table 3, were highly similar to those obtained in Study 1. Some of the demographic variables (age and to some extent race/ethnicity), as well as political conservatism and general system justification, were associated with a range of stigmatizing responses in Models 1 and 2. Nevertheless, ESJ was the most consistent correlate of negative reactions once all variables were taken into account in Model 3. In the full models, ESJ was the only statistically significant unique predictor of social intolerance, personal blame, negative stereotyping, pessimistic recovery beliefs, and exclusionary sentiments. There was little evidence of multicollinearity (tolerance = .72, VIF = 1.40; tolerance = .67, VIF = 1.49; and tolerance = .62, VIF = 1.61, for PO, GSJ, and ESJ, respectively). Next, we consider these results in more detail.

Social Tolerance

Of the three political psychology variables of interest, ESJ was the strongest unique predictor of social intolerance once all variables, including demographics, were included (β = -.233, $p < .001$). Although political conservatism was associated with lower tolerance in

[5] Race/ethnicity was coded as 0 = not white, 1 = white, sex as 0 = male, 1 = female. Age was categorized into six brackets, such that 1 = 18-24 years, and from there on in 10-year intervals (i.e., 2 = 25-34), with the last category of 6 = 65 or older. Education was categorized into three brackets, 1 = less than high school/high school graduate, 2 = some college, no degree, and 3 = bachelor's degree or higher. Family income was coded into seven brackets, such that 1 = less than $15,000, and from there on in 10,000 increments (i.e., 2 = $15,000 to 24,999), with the final bracket of 7 = $100,000 or more.

Model 2, it did not remain significant once ESJ was included in Model 3. Being younger, white, and having a lower family income was associated with more tolerance after adjusting for other variables.

Personal Blame

Economic system justification was the strongest unique predictor of blaming people with mental illness for their plight, after adjusting for all other variables ($\beta = .205$, $p < .001$). General system justification was also associated with personal blame ($\beta = .189$, $p < .001$).

Negative Stereotypes

Economic system justification was the strongest predictor of negative stereotypes about mentally ill people being dangerous, after adjusting for all other variables ($\beta = .173$, $p < .001$). Political conservatism and being non-white and older were also associated with negative stereotyping in Model 3, but these effects were not as strong as that of ESJ.

Recovery Pessimism

Economic system justification was the strongest correlate of pessimism about recovery from mental illness, after adjusting for all other variables ($\beta = .172$, $p < .001$). Political conservatism, GSJ, being younger and non-white also remained significant correlates in Model 3, but these effects were not as strong as that of ESJ.

Exclusionary Sentiments

Economic system justification was the strongest predictor of exclusionary sentiments, such as support for isolation and sterilization, after adjusting for all other variables ($\beta = .157$, $p < .001$). Political conservatism, GSJ, and being younger were also significant correlates, but these effects were not as strong as that of ESJ.

Demographic Moderators

At the request of an anonymous reviewer, we comprehensively investigated race/ethnicity, gender, age, education, family income, and political orientation as potential

moderators of the effects described above. The positive association between ESJ and stigmatization remained statistically significant across all moderation analyses. For most of these analyses, interactions between ESJ and demographic variables were statistically non-significant. For age, and in some cases race and political orientation, interactions were significant, but the effect sizes were small (see Appendix B in the SOM).

Discussion

In Study 2, we surveyed a nationally representative sample of 1,028 Americans and both replicated and extended the findings from Study 1. In both studies, we observed that ESJ was the strongest and most consistent correlate of stigmatizing responses towards individuals with mental illness. Across all traditional measures of stigma—social intolerance, personal blame, negative stereotyping, recovery beliefs, and exclusionary sentiments—economic system justification was the best unique predictor of negative responses, even after adjusting for demographic variables, political orientation, and general system justification. A clear limitation of our first two studies, however, is that they both used cross-sectional, observational methods, making it impossible to address questions about causality. It is conceivable, at least, that people with more stigmatizing attitudes toward people with mental illness might embrace economic system justification as a *post hoc* rationalization. To address this ambiguity, we conducted an experiment in which we manipulated economic positioning.

Study 3

In Studies 1 and 2, a tendency to justify the economic system emerged as the strongest and most consistent correlate of stigmatizing reactions toward individuals with mental illness across a very broad range of measures. An open question, however, is whether an individual's position in the economic system affects mental illness stigma. Therefore, in our third study we experimentally manipulated the personal financial status of vignette characters to investigate how their position within the economic system affects stigma.

Economic positioning could affect stigma differently depending on the problems the individual is experiencing. Drawing on previous evidence (Crisp et al., 2000; Hazell et al., 2022), including a pilot study (see Appendix C, SOM), we chose vignettes depicting individuals meeting the DSM criteria for two common mental health conditions affecting more than 30 million Americans (Pathak & Makk-Frid, 2025) that are similarly stigmatized, namely depression and social phobia. In Study 1 and in prior research, having personal experiences of mental illness was associated with fewer negative reactions. We therefore investigated whether personal experiences would attenuate the effects of economic positioning on stigmatization.

Method

Participants

In May of 2023, U.S. participants were recruited through the Prolific platform (N = 120) and paid $1.00 for completing the study. One participant was excluded for failing to pass the same attention check used in Study 1, and another for taking too long to complete the survey.[6] The final analytic sample consisted of 118 participants (median age 36; age range 19–72; 54 female, 61 male, 3 nonbinary/other/missing). The modal level of education was a bachelor's degree (43.2%). The median family income bracket in the previous year was $50,000–$74,999. The racial/ethnic breakdown was 67.8% white, 10.2% Asian, 9.3% Hispanic/Latinx, 7.6% Black/African American, and 4.2% more than one race.

Procedure and Materials

The study had two parts: (a) an experimental vignette in which we manipulated the economic position of a person with mental illness, followed by social tolerance items, and (b) questions about personal experience of mental illness and demographics.

[6] Two participants used more time to respond than allowed by Prolific by default. However, one of them explained that this was due to a technical glitch. After closer scrutiny, this seemed likely, so the participant's responses (which had been recorded in total) were included.

Experimental vignette. Building on work by Lebowitz and Ahn (2014), we presented participants with detailed vignettes of four fictitious characters (Alex, Terry, Michelle, and Nicole) who varied in terms of diagnosis (major depression or social phobia) and financial status (economically self-sufficient or not). The vignettes, reproduced in the SOM (Appendix D), did not include diagnostic labels, but the descriptions were designed so that symptoms met DSM criteria for either major depressive disorder or social phobia. To keep work status constant, all characters were employed (and two were attending college at the same time). In the *low financial status* conditions, people were described as earning little money and having financial problems. In the *high financial status* conditions, by contrast, they were described as making "very good money" and having no financial problems.[7]

Thus, there were four experimental conditions, manipulated in a within-participants fashion: (1) depression, high financial status; (2) social phobia, high financial status; (3) depression, low financial status; and (4) social phobia, low financial status. Pairings were counterbalanced across participants, so that each person was presented equally often as having low vs. high financial status. The presentation order of the four vignettes was semi-randomized separately for each participant, so that an equal count of presentations was maintained for each order. Vignettes were presented first, with each followed by a round of social tolerance items. The attention-check item was presented after the vignette questions, followed by questions about personal experiences and demographic characteristics.

Social tolerance. Our primary interest was in investigating whether the individual's position within the economic system affected the degree to which they were stigmatized on measures of social tolerance (the opposite of social distance). Participants were asked to use a scale ranging from 1 ("strongly disagree") to 5 ("strongly agree") to answer the following questions about each of the characters: "I would be willing to move next door to…"; "I

[7] The exact wordings of scenarios can be found in SOM, Appendix C.

would be willing to spend an evening socializing with…"; "I would be willing to make friends with…"; "I would be willing to start working closely with…"; and "I would be willing to have… marry into the family."

Survey questions. In the second part of the study, we asked participants whether they had personal experience of mental illness (yes/no), and if so, to specify how.[8] This question was followed by questions about demographics.

The study was approved by the New York University Institutional Review Board. The data file can be accessed here:

https://osf.io/yz2e6/?view_only=e577ab9883084e44a842f071154d3f06

Results

A mixed 2 x 2 x 5 ANOVA (financial status x problem x type of social engagement) with personal experience (no vs. yes) as a between-participants factor showed that the type of social engagement affected the results (F[3.26,38.62] = 24.38, $p < .001$, $\eta_p^2 = .174$). Participants were more willing to move next door, spend an evening socializing, and to make friends with the characters than to work closely with them. Having the person marry into the family was the least tolerated type of engagement. The main effect of mental health problem type was significant. Social tolerance was higher towards individuals who suffered from social phobia than depression, $F(1,116) = 18.79$, $p < .001$, $\eta_p^2 = .139$ (see Figure 1).

Importantly, financial status affected social tolerance, $F(1,116) = 5.78$, $p = .018$, $\eta_p^2 = .047$. As shown in Figure 1, people expressed more tolerance toward individuals who were high vs. low in financial status. The effect of financial status was the same regardless of problem type or social engagement type (i.e., no 2- or 3-way interactions).

[8] Sixty-one per cent reported having personal experience of mental illness. Respondents frequently used one or more diagnostic labels (most commonly depression and anxiety) when asked to specify the nature of their experience, but this does not necessarily mean they had received a clinical diagnosis.

Participants with previous experiences of mental illness were more tolerant (M = 4.05 [3.82, 4.27]) than participants with no such experience (M = 3.73 [3.55, 3.90]), $F(1,116)$ = 4.95, p = .028, η_p^2 = .041. There was no interaction between personal experience and financial status, indicating that the financial status manipulation did not affect participants differently depending on whether or not they had experienced mental illness, $F(1,116)$ = 2.58, p = .11. All other interactions were non-significant.

Discussion

In Study 3, we investigated the effects of economic positioning, operationalized as financial status, on social tolerance toward vignette characters described as suffering from major depression or social phobia. Higher financial status increased social tolerance for the characters regardless of the type of mental health problem. In addition, personal experience of mental illness increased social tolerance. The effect of financial status did not differ depending on whether or not the participants had personal experience of mental illness.[9]

These results extend the findings from Studies 1-2, demonstrating that there is a causal association between economic factors and mental health stigmatization. For conditions such as depression and social phobia, an individual's position in the economic system shaped how others responded to them, regardless of whether perceivers had experienced mental illness themselves. While participants with personal experiences of mental illness were more tolerant in general, even these participants were more likely to distance themselves from poorer (vs. wealthier) individuals suffering from mental illness.

General Discussion

Historically, people perceived as "mad" were not treated as a separate social group. In

[9] In a pilot study we explored the possibility that economic system justification would interact with the financial status manipulation but found it did not. Instead, we observed two main effects: participants who scored higher on ESJ engaged in more stigmatization, and target persons meeting the criteria for depression who were described as lower (vs. higher) in financial status were more stigmatized. The results were less clear for characters with schizophrenia (see Appendix C, SOM).

Britain, they were—until the mid-18th century—considered part of a much larger class, which included the poor and the physically disabled, among others (Scull, 1993). Today, socioeconomic disadvantage is known to be one of the most important determinants of mental health outcomes (Kirkbride et al., 2024). Disadvantages in education, finance, occupation, and living standards are all linked to poorer mental health (Allen et al., 2014), and economic hardships are associated with increased risks of depression, anxiety, and substance abuse (Frasquilho et al., 2016).

For all of these reasons, scholars have argued that it is important to understand psychological distress—and the public's responses to it—in the broader context of existing social, economic, and political institutions (e.g., Hansen et al., 2014; Lewis et al., 2025; Metzl & Hansen, 2018; Moncrieff, 2022; Pybus et al., 2023). Our research program confirms that people's beliefs about the economic system and economic outcomes such as wealth and poverty are indeed closely tied to how they respond to the psychological distress of others. We addressed this topic from the perspective of system justification theory, which suggests that—to varying degrees, depending upon personal and situational factors—people are motivated to defend and justify the societal status quo and, consequently, to blame or ostracize individuals for their failure to thrive under present conditions, rather than blaming the social system itself (Jost, 2020). Moreover, people who are (fairly or unfairly) seen as unable to contribute to economic productivity and success—and may instead draw on public resources—are especially likely to be stigmatized. Thus, we hypothesized that poorer (vs. wealthier) individuals who contend with mental illness should be especially vulnerable to stigmatization.

Economic System Justification and Stigmatization of Mental Illness

In two separate surveys, including a nationally representative survey of U.S. adults, we observed that ideological justification of the economic system was the strongest and most

consistent unique predictor of stigmatizing responses across a wide range of measures including social distance, negative stereotyping, personal blame, recovery beliefs, and exclusionary sentiments. Previous research has found that political conservatism and related measures such as right-wing authoritarianism (RWA) were associated with stigmatization of mental illness (DeLuca & Yanos, 2016; Kvaale & Haslam, 2016; Phelan & Link, 2004). In the present research program, we observed that conservatism (and general system justification) were correlated with negative reactions in some cases, but economic system justification was a stronger and more consistent correlate of negative attitudes toward people with mental illness.

In an experimental study, we manipulated the economic position of vignette characters who met diagnostic criteria for two different psychiatric disorders and discovered a causal connection between economic standing and stigmatization. Individuals with depression and social phobia were more likely to be stigmatized when they were described as having a lower (vs. higher) position in the economic system—operationalized as earning less (vs. more) money—even though work status and psychiatric symptoms were kept constant.

These findings, taken in conjunction, support theoretical suppositions that system-justifying beliefs, especially with respect to the capitalist system, are relevant for understanding mental illness stigma (Jones & Corrigan, 2014; Watson et al., 2003). Our findings are also consistent with prior empirical results linking (a) economic system justification to reactions to other disadvantaged groups, such as homeless people, who are often associated with mental illness (Goudarzi et al., 2020), and (b) economic attitudes pertaining to neoliberalism and exclusionary responses to people with mental health problems (Eskin & Baydar, 2022). The idea that economic considerations are related to mental health stigmatization is also compatible with two major conclusions drawn on the basis of a multi-level study of 27 European countries, namely that: (c) people who are economically stressed

(vs. not) have more difficulty talking to a person with mental illness, and (d) lower GDP and higher income inequality at the country level were associated with more stigmatizing responses (Pybus et al., 2023). Thus, it appears that economic matters are relevant at the societal as well as individual level of analysis.

We consistently observed that personal experiences of mental illness were associated with less stigmatizing reactions across a wide range of measures. In Studies 1 and 3, participants with personal experience were less likely to endorse negative stereotypes, exhibited more social tolerance, and had fewer negative reactions toward individuals with mental illness overall, consistent with prior research (Angermeyer & Matschinger, 1996; DeLuca & Yanos, 2016). For the most part, genetic deterministic beliefs failed to correlate with stigmatization. In Study 1, we considered the possibility that belief in genetic determinism would help to explain stigmatization of people with mental illness but found that it played a relatively small role, especially in comparison with economic system justification.

Methodological Limitations, Practical Implications, and Social Interventions

One limitation of this research program is that we cannot speak to the relative importance of right-wing authoritarianism, social dominance orientation (individual support for group-based dominance), and economic system justification (e.g., Szabó et al., 2024).[10] Although ESJ was the best unique predictor of stigmatization in Studies 1 and 2, and the experimental manipulation in Study 3 demonstrated a causal connection between lower economic status and more stigmatization, we did not measure other similar constructs—apart from political conservatism and general system justification, which were less strongly associated with stigma in the first two studies. It would be useful in future research to investigate the relative contributions of authoritarianism and system justification and to

[10] In Hungary, Szabó et al. (2024) observed that RWA was a stronger unique predictor of mental illness stigma than general or economic system justification.

consider whether they might offer complementary, rather than competing, explanations for stigmatization, insofar as both emphasize the importance of "personal responsibility" and "self-sufficiency" in capitalist societies. A second limitation is that we relied heavily on self-report measures, as is the case in most social psychological research on stigma. We acknowledge that measures of actual behavior would be more informative and hope that future research will investigate the role of economic system justification in real-world settings.

A third limitation is that this research was conducted in the U.S., a "WEIRD" (Western, Educated, Industrialized, Rich, Democratic) country. Because it is emblematic of free-market capitalism, the U.S. is an important context in which to investigate beliefs about the economic system and their connection to stigmatization of people with mental illness. Future research, nevertheless, would do well to explore the role of economic system justification in non-WEIRD societies. However, it would be difficult to find a country in which questions about mental health are entirely unrelated to economic factors. Moreover, comparative research suggests that mental illness stigma includes certain core components—having to do with caring for children, marrying into the family, unpredictability and the possibility of self-harm—that are remarkably similar across different countries (Pescosolido et al., 2013). Another core component is the belief that people with mental illness are less productive than others, along with concerns that they should not hold positions of power or authority—beliefs that are embraced in many countries across the globe. Such beliefs are clearly linked to economic standing as well as perceptions of deservingness and entitlement, which are central to system justification processes (Jost, 2020; Lerner, 1980).

In terms of practical implications, we note that experts working in psychology and psychiatry have often approached mental illness stigma in terms of individual bias, as if it operated independently of social and economic structures. Our findings suggest that

researchers and practitioners should realize that beliefs about mental health are tied in various ways to overarching social, economic, and political systems and that people's economic position can directly affect the degree of stigmatization they experience. Clinicians, for instance, should strive for a holistic understanding of the social, economic, and political challenges their clients face.

Regarding possible interventions, our findings reinforce Corrigan's (2018) view that stigma is a complex phenomenon that does not respond very well to educational campaigns or message framing interventions. Communications that reinforce the biomedical model may make things worse by accentuating perceived differences between people seen as "healthy" versus "sick" (e.g., Haslam & Kvaale, 2015). Rather than reinforcing a biomedical lens, a more promising intervention, it seems, is one that emphasizes human rights for all, respect for legal capacity, and the transformation of mental health services toward a person-centered, recovery-oriented approach (Funk et al., 2025). In the context of climate action, it has also been possible to leverage system justification motivation on behalf of social change by framing pro-environmental initiatives as congruent with the ideals of the social system (e.g., Cutler et al., 2025; Mason et al., 2024). However, short-term communicative approaches will neither change the economic realities in which people live nor substantially alter other people's longstanding beliefs about the legitimacy of the economic system.

Our view is that it is necessary to move beyond mere recognition of structural determinants of mental health outcomes and to work toward social, economic, and epistemic justice by challenging dominant ideologies and institutions in even deeper ways (Jones, 2025; Lewis et al., 2025; see also Hansen et al., 2014; Metzl & Hansen, 2018). The perspectives of people with lived experience of mental illness remain overlooked in research and practice, thus creating blind spots, distorting understandings of the phenomena in question, and hindering attempts to help (Corrigan, 2018; Jones, 2025). The field of *mad studies* has

emerged recently to challenge the status quo by seeking to take seriously the diversity of people's perspectives, questioning reductionist conceptions of mental health, and opening up space for new understandings of mental distress and difference (Lewis et al., 2025).

Concluding Remarks

For a long time the social, economic, and political dimensions of mental health were addressed more or less exclusively by sociologists and public health researchers. Over the past decade or so, however, the importance of these dimensions has become increasingly clear to psychologists and psychiatrists as well. There is growing interest now across disciplines in how socio-economic and other structural factors could be better taken into consideration when it comes to mental health research, education, and the delivery of clinical services (e.g., United Nations General Assembly, 2020; Hansen et al., 2014; Hatzenbuehler & Link, 2014; Kirkbride et al., 2024; Kvaale & Haslam, 2016; Lewis et al., 2025; Metzl & Hansen, 2018; Pybus et al., 2023). Moreover, researchers and clinicians are asking fundamental questions about how psychological distress should be conceptualized and defined, how system-sanctioned definitions shape our understandings of it, and what the economic and political implications of these understandings are (e.g., Allsopp et al., 2019; Lewis et al., 2025; Moncrieff, 2006; Moncrieff, 2022; Whitaker & Cosgrove, 2015). Scholars and practitioners are also raising new questions about who is afforded the social power to promote scientific knowledge and lead initiatives to decrease stigma and alleviate injustice (Corrigan, 2018; Jones, 2025; Lewis et al., 2025). These developments mark a clear shift away from the longstanding assumption that the best approach to combating stigmatization is to reinforce the individualistic biomedical perspective, as previous public campaigns sought to do. Instead, new approaches look for solutions that go beyond stigma itself, such as ways of ameliorating social, economic, and political disparities and, in so doing, reconfiguring traditional hierarchies of status and power.

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Figure 1. Higher (vs. lower) financial status increased social tolerance towards vignette characters with symptoms of major depression and social phobia. Error bars depict 95% confidence intervals.

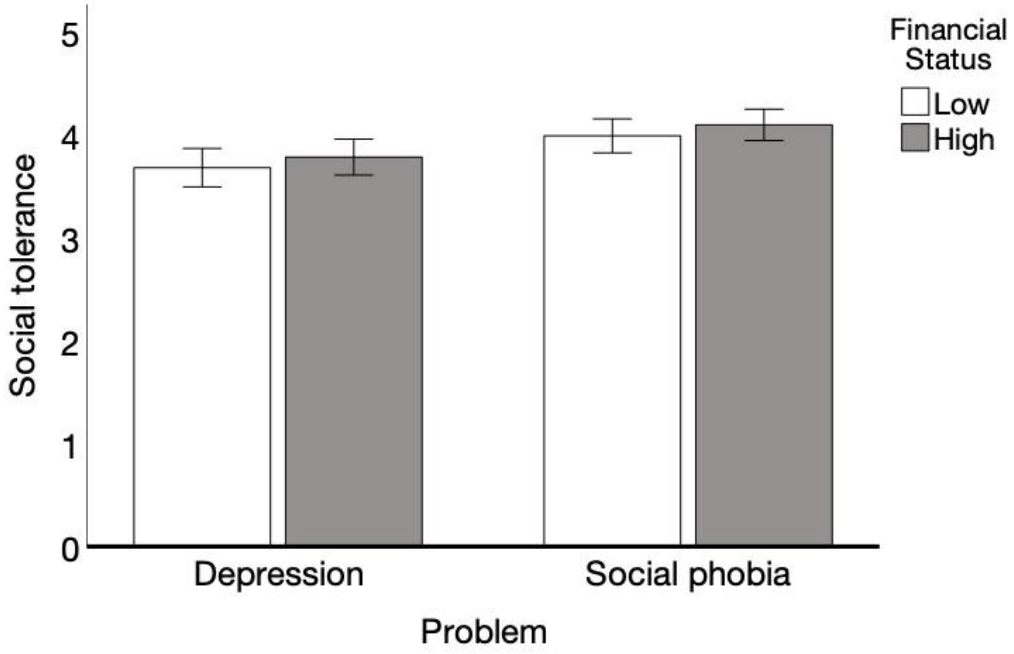
Financial Status
Low
High
Social tolerance
0
1
2
3
4
5
Depression
Social phobia
Problem

Table 1. *Hierarchical Regression Models: Predictors of Mental Illness Stigma (Study 1)*

	Negative Stereotypes (AMIS I)				Recovery Beliefs (AMIS II)				Reported and Intended Behaviors (RIBS)			
Predictors	Model 1	Model 2	Model 3	Model 4	Model 1	Model 2	Model 3	Model 4	Model 1	Model 2	Model 3	Model 4
Age	.082	.091	.047	.078	-.008	-.013	.011	-.045	-.020	-.030	.002	-.043
Sex	-.144**	-.128*	-.114*	-.104*	.104*	.094	.073	.055	.103	.083	.064	.050
Race	-.034	-.017	-.050	-.036	.021	.011	.035	.010	.004	-.016	.009	-.010
Education	-.057	-.050	-.043	-.043	-.008	-.012	-.014	-.015	.020	.011	.014	.013
Family income	.063	.042	.022	.034	-.092	-.080	-.053	-.075	-.054	-.030	-.002	-.019
Personal experience		-.155**	-.122*	-.109*		.095	.079	.056		.182***	.166**	.148**
Belief in genetic determinism			.040	.032			.085	.098*			.045	.055
Political conservatism			.131*	.026			-.129*	.058			-.085	.063
GSJ			.147**	.026			-.143*	.073			-.214***	-.042
ESJ				.265***				-.473***				-.374***
adj. R^2	.020	.040	.086	.120	.006	.012	.057	.169	<.001	.030	.087	.156
ΔR^2	.033	.023	.052	.035	.019	.009	.052	.111	.014	.032	.064	.070
ΔF	2.49*	8.72**	7.00***	14.58***	1.43	3.21	6.78***	48.93***	1.00	12.02***	8.57***	30.18***

Note. GSJ = General system justification, ESJ = Economic system justification, AMIS = Attitudes toward mental illness, RIBS = Reported and intended behavior scale. Sex coded as 0 = not female, 1 = female; race as 0 = not white, 1 = white; personal experience of mental health services as 0 = no, 1 = yes. Income and education coded on 8-point scales. All coefficients are standardized.
$^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$.

Table 2. *Hierarchical Regression Models: Predictors of Community Attitudes Toward the Mentally Ill (Study 1)*

	Authoritarianism				Benevolence			
Predictors	Model 1	Model 2	Model 3	Model 4	Model 1	Model 2	Model 3	Model 4
Age	-.061	-.050	-.089	-.044	.089	.080	.113	.054
Sex	-.115*	-.095	-.070	-.056	.122*	.104*	.077	.058
Race	-.023	-.003	-.039	-.020	.015	-.003	.028	.003
Level of education	.000	.008	.015	.016	.022	.014	.014	.012
Family income	.057	.032	.001	.018	-.057	-.035	.002	-.021
Personal experience		-.187***	-.157**	-.139**		.168**	.147**	.124**
Belief in genetic determinism			-.068	-.079			.104*	.118*
Political conservatism			.191***	.041			-.151**	.044
GSJ			.169**	-.005			-.219***	.007
ESJ				.379***				-.493***
adj. R^2	.007	.039	.117	.188	.013	.038	.129	.251
ΔR^2	.021	.034	.084	.072	.027	.027	.097	.121
ΔF	1.54	12.79***	11.68***	32.27***	1.99	10.25**	13.53***	59.06***

	Social Restrictiveness				Community Mental Health Ideology			
Predictors	Model 1	Model 2	Model 3	Model 4	Model 1	Model 2	Model 3	Model 4
Age	-.005	.006	-.037	.008	.012	-.002	.042	-.005
Sex	-.119*	-.096	-.074	-.059	.081	.054	.035	.020
Race	-.035	-.012	-.049	-.030	.022	-.007	.030	.010
Level of education	.004	.014	.020	.021	-.006	-.018	-.028	-.029
Family income	.040	.012	-.018	.000	-.117*	-.083	-.060	-.078
Personal experience		-.211***	-.178***	-.160**		.258***	.222***	.203***
Belief in genetic determinism			-.033	-.043			-.003	.008
Political conservatism			.179**	.029			-.187***	-.032
GSJ			.175**	.001			-.122*	.058
ESJ				.379***				-.392***
adj. R^2	.003	.044	.118	.189	.007	.069	.125	.201
ΔR^2	.017	.042	.080	.072	.021	.064	.062	.077
ΔF	1.23	16.24***	11.11***	32.27***	1.51	25.14***	8.60***	35.09***

Note. GSJ = General system justification, ESJ = Economic system justification. Sex coded as 0 = not female, 1 = female; race as 0 = not white, 1 = white; personal experience of mental health services as 0 = no, 1 = yes. Income and education both coded on 8-point scales. All coefficients are standardized.
$^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$.

Table 3. *Hierarchical Regression Models: Predictors of Mental Illness Stigma (Study 2)*

Predictors	Social Tolerance			Personal Blame			Negative Stereotypes			Recovery Pessimism			Exclusionary Sentiments		
	Model			Model			Model			Model			Model		
	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3
Age	-.231**	-.183**	-.184**	.041	-.066	-.064	.185**	.113**	.114**	-.046	-.134**	-.133**	-.021	-.112*	-.111*
Education	-.012	-.026	-.030	-.015	-.001	.002	-.021	.004	.007	.024	.043	.046	-.019	.004	.007
Family income	-.096*	-.079	-.068*	.015	-.021	-.031	.104*	.078	.070*	.024	-.007	-.015	.046	.015	.008
Sex	-.033	-.040	-.056	-.106**	-.079	-.066	-.041	-.033	-.021	-.071	-.053	-.042	-.060	-.044	-.034
Race/ethnicity	.161**	.176**	.176**	-.024	-.042	-.042	-.117**	-.141**	-.141**	-.067	-.089*	-.089*	.003	-.022	-.021
Political conservatism		-.114**	-.022		.136**	.056		.195**	.127**		.165**	.097*		.191**	.130**
GSJ		-.095*	-.012		.262**	.189**		.125**	.064		.193**	.132**		.186**	.130**
ESJ			-.233**			.205**			.173**			.172**			.157**
adj. R^2	.059	.082	.115	.010	.100	.125	.043	.102	.120	.009	.080	.097	.001	.079	.094
ΔR^2	.063	.025	.034	.015	.091	.026	.048	.060	.019	.014	.072	.018	.006	.080	.015
ΔF	13.82**	13.78**	39.39**	3.03	52.19**	30.72**	10.31**	34.41**	21.76**	2.95	39.95**	21.04**	1.21	44.48**	17.30**

Note. GSJ = General system justification, ESJ = Economic system justification. Age coded 1-6 (1 = 18-24 to 6 = older than 65); sex as 0 = not female, 1 = female; race as 0 = not white, 1 white; education 1-3 (1 = high school graduate or less, 2 = some college, 3 = Bachelor's degree or higher); and family income 1-7 (1 = less than $15,000 to 7 = $100,000 or more). All coefficients are standardized.
*$p < .01$, **$p < .001$.