# EXAMINATION OF SOCIETAL PERCEPTION AND TRUST BEHAVIOUR TOWARDS PEOPLE LIVING WITH SCHIZOPHRENIA

*Dissertation submitted to Kerala University*

*In partial fulfilment of the requirements for the award of the Degree of*

**M. Sc. Counselling Psychology**

By

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2021- 2023

**CERTIFICATE**

This is to certify that the Dissertation entitled "**Examination of societal perception and trust behavior towards people living with Schizophrenia"** is an authentic work carried out by Seetha Lekshmy V S, Reg. No. 60421115021 under the guidanceof Dr. Ammu Lukose during the fourth semester of M.Sc. Counselling Psychology programme in the academic year 2021- 2023.


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## DECLARATION

I, Seetha Lekshmy V S, do hereby declare that the dissertation titled "**Examination of societal perception and trust behavior towards people living with Schizophrenia",** submitted to the Department of Counselling Psychology, Loyola College of SocialSciences, Sreekariyam, under the supervision of Dr Ammu Lukose, Assistant professor of the Department of Counselling Psychology, for the award of the degree of Master's in Science of Counselling Psychology, is a bonafide work carried out by me and no part thereof has been submitted for the award of any other degree in any University.

Sreekariyam

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## ACKNOWLEDGEMENT

I would like to express my deepest gratitude and appreciation to all those who have supported and contributed to the completion of this dissertation.

First and foremost, I am immensely grateful to my guide, for her guidance, expertise, and unwavering support throughout the entire research process. I am also grateful for her collaboration with Dr. Naren P Rao, which provided me with the invaluable opportunity to embark on this research endeavor. Her invaluable insights, constructive feedback, and continuous encouragement have been instrumental in shaping the direction of this work. Her collaboration has opened up numerous opportunities for learning and growth, and I am truly fortunate to have had the privilege of working with her. Her dedication to my growth as a student is truly commendable, and I am grateful for her ongoing commitment to my academic development. Her guidance has been a driving force behind my progress, and I look forward to continuing to learn and grow under her mentorship.

I would like to extend my heartfelt appreciation to Dr. Naren P. Rao for his invaluable contribution to my research journey. Dr. Rao's guidance and support in the development of my research proposal have been instrumental in shaping the foundation of my work. His expertise in psychology and his dedication to academic excellence have not only provided me with a solid research framework but have also inspired me to strive for a deeper understanding of the subject.

I'm profoundly grateful to Arpitha Jacob for her unwavering guidance, insightful mentorship, and dedication, enriching my understanding of psychology and research methodologies. Her constant support has not only deepened my knowledge but has also inspired me to think critically and approach research with rigor.

I would like to express my gratitude to Ms Jesline Maria Mamen, Assistant professor and Head of the Department of Counselling Psychology for providing constant support to complete the research.

I wish to extend my heartfelt gratitude to Maya Ajikumar and Athmaja Panickar for their unwavering dedication and support, which played an indispensable role in the successful completion of my data collection for the research. I am deeply thankful for her invaluable contributions.

I would like to extend my heartfelt thanks to Anoop George for his valuable moral support and insightful discussions that significantly aided my research journey. His unwavering encouragement and willingness to engage in thoughtful conversations have been a constant source of motivation during challenging times. I am sincerely grateful for his commitment

to my growth as a student and researcher.

I extend my heartfelt gratitude to Rahul and the Gladstein, Department of Sociology for their vital assistance in data collection. Their dedicated efforts were pivotal to the success of my research.

I also want to express my sincere thanks to Greena John and Jacob Mathew for their invaluable contributions, both in data collection and providing moral support.Their contributions have been integral to my progress, and I am truly thankful for their support.
Next, I would like to acknowledge the assistance and support received from the faculties of my college and Loyola Research Collective. Their dedication to education and research has created a stimulating academic environment that nurtured my intellectual growth and development.

My heartfelt thanks go to my family and friends for their unwavering support, encouragement, and understanding throughout this journey. Their love, patience, and belief in me have been the driving force behind my perseverance and determination.

I am indebted to the participants who willingly shared their time, insights, and experiences for this study. Their contributions were invaluable in providing the necessary data to fulfill the objectives of this research.

Lastly, I want to express my gratitude to all those who have crossed my path and influenced my academic journey in ways big and small. Your guidance, conversations, and shared experiences have shaped my thinking and broadened my horizons.

Completing this thesis would not have been possible without the collective support and encouragement of all those mentioned above and many others who have contributed in various ways. Though their names may not appear in this acknowledgement, their influence and support are deeply appreciated.

With Regards
Seetha Lekshmy V S

# EXAMINATION OF SOCIETAL PERCEPTION AND TRUST BEHAVIOUR TOWARDS PEOPLE LIVING WITH SCHIZOPHRENIA

Course: MSc Counselling Psychology

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## ABSTRACT

**Aim:** To examine the level of trust shown by healthy individual towards people living with schizophrenia compared to healthy controls (HV)

**Methods:** A total of 50 participants with a mean age of 31.92(SD = 10.9, Range= 21 To 50 years). years were recruited using purposive sampling method from Trivandrum and Kollam districts of Kerala. The study uses a neurocognitive game called trust game or investment game, popularly used in behavioural economics research, designed by Berg et al to examine trust behaviour towards (SCZ). For data collection, along with trust game, the Community Attitude Towards Mentally Ill scale (CAMI), was used. Participants between the age of 18 to 50 years with absence of lifetime axis 1 diagnosis and with minimum education of seven years were included and participants with serious mental illness or who score below 24 on HMSE Hindi Mental Status Examination scale or individuals with intellectual disability disorder, individuals with family history of psychotic disorders in first degree relatives were excluded from the study. The rationale behind this exclusion is the exposure and the subsequent change in attitude and perception towards mentally ill as a result of close contact with the patients. Hindi Mental Status Examination scale (HMSE), risk propensity scale, Kessler Psychological Distress Scale (K 10) and digit symbol substitution test were used to recruit participants asper inclusion exclusion criteria. The data were found to be consistent with a normal distribution based on the results of the Shapiro-Wilk tests, justifying the use of parametric tests for the analyses.

**Results:** - It was found that 76% of the participants exhibited medium stigma and 22% low stigma towards people with mental illness. Also, age exhibited a strong negative correlation with community mental health ideology (r= -0.482**) and positive correlations with CAMI (r = 0.043), social restrictiveness (r = 0.184), and investment in SCZ (r = 0.341*). These correlations are statistically significant at the 0.05 level.

The results indicate significant difference in investment between SCZ and HV($\eta^2$=0.089*). However, no significant difference emerge in pre and post investments for either group. Notably, SCZ investments exhibit positive correlations with authoritarianism attitude, age, trust propensity, and risk propensity, while HV investments correlate solely with trust propensity and risk propensity. Age, authoritarianism, and social restrictiveness are robust predictors of SCZ investments, encompassing pre, post, and total investments. Meanwhile, benevolence significantly predicts HV pre, post, and total investments. Stigma and trust propensity share a negative correlation, with stigma significantly influencing trust propensity. This study underscores the complex interplay between psychological factors, stigmatization, and trust behaviors, contributing to a more comprehensive understanding of trust dynamics in the context of mental health.

**Conclusion:**

The study reveals nuanced ways in which stigma can manifest in investment behaviours. Notably, individuals displaying higher levels of Authoritarianism (AU), which signifies stigma, exhibit a greater inclination to invest more in individuals with schizophrenia (SCZ). Conversely, those with elevated Social Restrictiveness (SR), another indicator of stigma, demonstrate a reduced investment tendency towards individuals with schizophrenia. Additionally, individuals with lower Benevolence (BE), reflecting stigmatizing attitudes, show a heightened investment in healthy volunteers (HV) compared to those with higher BE scores. However, this pattern of increased investment in healthy volunteers due to low Benevolence does not extend to investment in individuals with schizophrenia. These findings underscore the intricate interplay between different dimensions of stigma and their influence on investment decisions, shedding light on the complex dynamics at play in trust-related interactions and mental health stigma.

Keywords – *Schizophrenia, Stigma, Trust, Trust game, Kerala*

# CHAPTER I

# INTRODUCTION

Schizophrenia is a chronic brain disorder characterized by positive and negative symptoms. Positive symptoms refers to symptoms that are abnormally found, such as hallucination and delusion whereas negative symptoms refers to the lack or deficits in functioning, such as avolition ( inability to initiate and persist in goal-directed activities), anhedonia (inability to feel pleasure in normally pleasurable activities), apathy (lack of motivation), asociality, alogia (poverty of content of speech, poverty of speech), affective blunting (inability to feel positive or negative emotions), attention impairment, etc. Although schizophrenia can develop at any age, the average age of onset is late adolescents and early adulthood. The disorder is also characterized by cognitive impairment i.e., deficits in attention, verbal learning, working memory, executive functioning, etc and also impairment in social cognition. Bilder, 2002 found mild to moderate impairment in verbal fluency, attention, processing speed and working memory, and also noted severe deficits in executive functioning and declarative verbal memory. It was also found that when people living with schizophrenia engaged in tasks of working memory, they showed less pre-frontal brain activation compared with healthy controls (Cannon et al., 2005).

## Schizophrenia, Trust and stigma

Schizophrenia is characterized by profound challenges in social functioning, as evident in its core symptoms encompassing social withdrawal, paranoid delusions, hostility, and compromised trust in others (Morrison et al., 1987). Within human interactions, trust and reciprocity hold pivotal roles, influencing both competitive and cooperative behaviours and significantly contributing to an individual's effective navigation within a complex social milieu.

Empirical investigations have unveiled that individuals grappling with schizophrenia tend to exhibit diminished levels of trust in contrast to their healthy counterparts. Additionally, research has illuminated that these patients encounter difficulties in adapting their trusting behaviours, regardless of receiving information about the trustworthiness of others or specific direct behavioural feedback (Kathrin,A et al., 2012). Such challenges might pose considerable obstacles for patients in securing and retaining employment, cultivating meaningful relationships, and achieving overall successful integration into society. Notably, cross-cultural meta-analyses have underscored substantial variations in the manifestations of trust across different societies (Johnson et., 2011)

In the realm of social interactions, the dynamics of trust behaviour are inherently intricate and substantially hinge on reciprocation from the other party. Pre-existing biases and assumptions hold a pivotal sway over an individual's inclination to trust. Simultaneously, the persistence of stigma towards individuals grappling with mental illnesses, particularly those afflicted by psychotic disorders, remains prevalent within society (Rossler et al., 2016; Corrigan et al.,2002). Despite the widespread dissemination of knowledge about mental health conditions, individuals with such conditions continue to experience discrimination and exclusion from various opportunities (Stuart et al.,2006). Consequently, individuals diagnosed with schizophrenia may confront perceptions of being less trustworthy in comparison to their healthy counterparts. Thus, the primary objective of this study is to systematically explore and assess the extent of trust displayed by healthy individuals towards individuals diagnosed with schizophrenia, in contrast to their interactions with healthy controls.

**Stigma**

The stigma associated with mental illness adds to the burden of schizophrenia. Many people even find the effect of stigma to be more distressing when compared to the disease itself ( Thornicroft, 2006). Stigma often leads to isolation and social exclusion. The term stigma refers to "a social devaluation of a person" (Thara and Srinivasan, 2000). The concept was initially described by Erving Goffman in 1963.

Stigmas are of different types. Mainly it includes self stigma, public stigma and structural stigma. (Corrigan, Powell, & Rusch, 2012). Among these types of stigma, for the purpose of current dissertation, Public stigma will be primarily discussed about.

There are different types of stigma

- Public stigma –Public stigma is an external evaluation of someone else, which is based upon the norms of society (Overton & Medina, 2008). It refers to the discrimination and prejudice endorsed by general population regarding various kinds of mental illnesses and conditions. Perceived stigma, is highly related to public stigma and it is referred to ones belief about attitude of others towards mental illness.

- Self-stigma – It is also called as internalized stigma and refers to the internalization of prejudice and negative attitude towards oneself regarding ones own mental illness. Self-stigmatization is a three-stage process in which a person assigns a social impairment to themselves, internalises it, and assumes that others will treat them poorly or regard them with disdain. (Yanos PT, DeLuca JS, Roe D, Lysaker PH. 2020)

- Stigma by association – It is also referred to as courtesy stigma. The term courtesy stigma is coined by Erving Goffman in 1963. It involves the negative attitude and prejudice associated with people somehow associated with people with mental illness

like medical professionals, families, care providers. It contributes to burn out among care givers and medical health professionals.

- Institutional stigma, it is also referred to as structural stigma. It involves government policies and private organizations that intentionally or unintentionally limit opportunities for people with mental illness which leads to legitimization of stigmatized status.

Stigma is less among Asian and African countries but it is unclear whether this finding is due to the influence of their culture of lack of adequate research regarding the same. (Fabrega et al., 1991) Also the available research suggests that stigma associated with mental illness is less severe than in western culture. (Fabrega H. 1991; Ng CH. 1996;Kasten,L. 2018)

**Impact of stigma**

Stigma have a negative psychological, economic, political and social consequences for individuals with mental illness. Higher rates of self-stigmatization are linked to higher rates of generalised mental illness, social anxiety, higher rates of depression, low self-esteem, lower levels of hopefulness, poorer social and occupational functioning, less successful treatment outcomes, a lack of social support as well as a lack of co-operation during treatment, and finally, lower quality of life. (Ociskova M, Prasko J, Kamaradova D, Grambal A, Sigmundova Z. 2015)

- Impact on self esteem

Stigma and especially the negative stereotypes associated with the stigma can have a negative impact on an individual's self esteem ( Blankertz, 2001).

- Effect on self efficacy

Self-efficacy in turn gets influenced by low self esteem and negative cognitions (Blankertz, 2001). When the people affected by mental illness perceive that others, even the individuals within their support system are judging and dehumanizing them, it detrimentally effects their self efficacy too. Stigma imposed by the others create a perception that people who are mentally ill are incapable to meet everyday responsibilities (Corrigan & Watson, 2002).

- Impact on help seeking behaviour

Negative attitude and stigma associated with mental illness a barrier for help seeking behaviour among people. (Clement et al. 2015, Corrigan, 2004; Corrigan, et al., 2014; Gary et al., 2009; Schomerus, et al., 2008; Sharp, et al., 2015; Thornicroft et al., 2008.)

National policy makers of united states have identified stigma as an important barrier to help seeking for mental health. How stigma against mental illness affects attitudes and behaviours related to getting care has been the subject of numerous scientific investigations. Higher personal stigma is often linked to less aid seeking among adults (Cooper, Corrigan, & Watson, 2003) and adolescents (Penn et al., 2005), according to studies looking at people's own stigmatising behaviours. Although this study did not differentiate between perceived personal stigma and perceived public stigma, it was found that participants who reported feeling embarrassed about receiving mental health treatment were less likely to feel the need for help or use mental health services (Mojtabai, Olfson, & Mechanic, 2002).

**Trust behaviour**

During social interactions and interpersonal connections, trust is crucial (Lewicki & Wiethoff, 2000). The building of trust begins at a young age and is a critical part of children's adaptive psychosocial development (Erikson, 1963). According to Colquitt, Scott, and LePine (2007) and Mayer, Davis, and Schoorman (1995), the trust process can be broken down into three concepts: trusting beliefs (i.e., trustworthiness), trusting intentions (i.e.,

willingness to be vulnerable), and trusting actions (e.g., reliance on others; Pillutla, Malhotra, and Murninghan, 2003). Individual differences in personality (propensity to trust) and state beliefs (trustworthiness) are examples of trait and state impacts on the trust process that are included in the category of "trust beliefs." The surroundings, the trustor, and perceptions of the trustee (based on behaviour, verbal interactions, etc.) all have an impact on the latter evaluation. Trust intentions are the readiness to expose oneself to a referent (such as a person or organisation). The behaviours one engages in when relying on the referent are known as trust acts. It should be remembered that trust intentions may not always match up with deeds. The social psychology literature has recognised that several constructs may contribute to subsequent behaviours (Ajzen, 1991). As a result, a trustor may have high intentions for trust yet not act in a trust manner. On the other hand, a trustor may act in a way despite having low trust intentions. To better precisely evaluate the trust process, it is crucial to clarify these three behaviours.

The inclination for someone to trust other people in general is referred to as their propensity to trust (Mayer et al., 1995; Hochreich & Rotter, 1970). Trust intentions and trustworthiness perceptions are both affected globally by propensity to trust (Colquitt et al., 2007; Jones & Shah, 2016). However, early in interpersonal contacts, when other information might not be available, the impact of trust propensity is most noticeable (McKnight, Cummings, & Chervany, 1998). In these circumstances, a person consciously compares the prospective costs and advantages of a given set of decision possibilities, and then, using the rational choice model, chooses the best course of action (Jones & Shah, 2016). If there is no other information, the person may act based solely on the dispositional biases they have brought to the circumstance. In terms of trust, in the lack of knowledge about another person, the choice to believe is likely to be influenced by an assessment of the possibility of suffering a loss versus

receiving a benefit for believing based on one's dispositional predisposition to believe. (Alarcon et al, 2018).

**Trust game**

A game of economic judgement is the investment/dictator scenario (Berg, Dickhaut, & McCabe, 1995). The game has been used to model trust since any stake (i.e., risk), whether it be social, financial, personal, or organisational in character, must exist for trust to be relevant (Parkhe & Miller, 2000). As a result, realistically vulnerable trust-based scenarios are a crucial prerequisite for trust research. In the investment/dictator game, which involves two players, person A is given an initial endowment and has the option of keeping it or sending some or all of it (depending on the experiment) to person B. The value of the money doubles or even triples if it is sent to person B. Then, Person B chooses whether to keep the cash or return it to Person A. The regulations of the game, such as how much money there is to start with and how much it will increase if sent to the other player, are normally known by the players. Because the players are vulnerable and are entrusting one another with their money, it is thought of as a trust game. The trust grows as more money is sent. The average amount sent in the investment/dictator game is around half the endowment, and person B typically returns between 30 and 40 percent of the money sent (Johnson & Mislin, 2011). Then Person B chooses whether to keep the money or send it to Person B.

The possibility of both financial loss and gain depending on their choice gives the investment/dictator game an edge over other trust scenarios like the Prisoner's Dilemma (see Wedekind & Milinski, 1996). According to research, players act differently depending on whether they win or lose the game (Thaler & Jonshon, 1990). Particularly, participants are frequently inclined to gamble more when there has been prior reward, such as earning money. The trust game continues to have significant drawbacks, though.

Contrary to the majority of naturalistic trusting relationships, the investment/dictator game scenario. First, according to Mayer et al. (1995), uncertainty or a lack of monitoring are essential components of trust. The trustor understands the trustee's activities in the investment/dictator game mentioned above, including how much of the total sum they sent back. Person A understands how much money Person B is capable of sending, for instance, if Person A sends Person B Rs10 and knows it would be doubled (Rs 20). If person B pays back Rs 6 (30% of Rs 20 according to a meta-analysis; Johnson & Mislin, 2011), person A knows how much to trust person B, therefore there is no doubt about whether one made the proper choice. There is no doubt as to whether the partner displayed a trustworthy behaviour in this situation, which is a typical problem with many trust games. Second, the task's excessive simplicity is a problem. There is no ability component involved in the decision to transfer the money, which limits the generalizability of traditional trust games to the trust process. Instead, the decision to deliver the money depends on the kindness and integrity components of trustworthiness. As the trustee's ability to carry out the pledged behaviour is a reliable predictor of trust intentions, trust is frequently more complex than a straightforward decision (Serva et al., 2005).

While expectations that exist prior to a social interaction can influence trust behaviour, trust can also grow dynamically during a social interaction. As a result, second-person paradigms, in which the participant is actually interacting with a partner, are the most effective ways to measure trust (Schilbach et al., 2013). The trust game is an illustration of such a paradigm (Berg et al., 1995).

**Theory of mind**

Theory of mind refers to the cognitive capability of making inferences about other's mental states i.e. beliefs, intentions and desires and using it to understand and predict behaviour. It includes identifying deception, hints, false beliefs, etc. In general, it has been found that people living with schizophrenia show deficits on theory of mind compared to healthy controls.

Attributional style or explanatory style refers to the manner in which people explain the cause of positive and negative life events to themselves. Normally, for positive events, people attribute responsibility to themselves whereas to others for negative events. People living with schizophrenia, especially with paranoid schizophrenia or persecutory delusion tend to attribute others rather than situation to negative events which is referred to as personalizing bias (Garety, et.al.,1999) (Bentall et.al., 2001). The mechanism help them maintain positive self-image, which comes at the cost of increasingly negative perception to others.

**Need and significance of the study**

The study aims to examine the societal perception and trust behaviour towards people living with schizophrenia (PwSz). The effects of schizophrenia on social functioning become apparent through symptoms like social isolation and compromised trust(Katherin et al., 2012). Trust is a fundamental element for effective human interactions and overall well-being. Individuals with schizophrenia exhibit diminished levels of trust, and their difficulty in adapting trust perceptions based on information further impedes their integration into society. Reciprocity and preexisting notions shape the level of trust people place in one another. Despite efforts to educate, stigmatization of those with mental health issues persists, limiting their

opportunities. Consequently, individuals with schizophrenia might face biased perceptions of being less reliable. This study bridges a research gap by investigating how individuals without schizophrenia perceive and place trust in those with the condition, thus the study will contribute to the growing body of literature on societal perception and stigma towards people living with schizophrenia (PwSz).

It will not only help gain more understanding regarding how people living with schizophrenia are perceived by the society but also will help examine the trust behaviour towards people living with schizophrenia. The study uses a novel neurocognitive game called trust game or investment game, popularly used in behavioural economics research, designed by Berg et at which is used to examine trust in an investment setting also adds to the relevance of the study.

Even though research has made huge progress in understanding the impact of various mental illness, it has only lately started to explain stigma in mental illness. It still require a lot of study and work to fully comprehend the scope of stigma and prejudice against people with mental illness. Also, there is considerable difference in findings from western and eastern countries relating to stigma research. According to Fabrega,H, 1991, stigma is less among Asian and African countries but it is unclear whether this finding is due to the influence of their culture of lack of adequate research regarding the same. Also, the available research suggests that stigma associated with mental illness is less severe than in western culture and this study would help shed some light on the above-mentioned gap. Also, there is significant gap in stigma literature researches in Kerala and the study aims to address this gap.

Also it has been proved that people with psychotic illness and their relatives with a very heightened risk of contracting the illness shows a lower level of trust when compared to healthy controls (Frett,A 2012). The present study examine the difference in trust

exhibited by healthy individuals towards people living with schizophrenia and healthy controls thus shedding light on whether the lower trust exhibited by the people with psychotic illness is due to the lower trust exhibited by healthy people towards them (simply reciprocating) or is it merely due to their impairment in social functioning.

With regard to a variety of health issues worldwide, stigma is a well-documented obstacle to health seeking behaviour, participation in care, and adherence to treatment. It is crucial to have an explicit theoretical framework to direct intervention development, measurement, research, and policy in order to stop the stigmatisation process and lessen the negative effects of health-related stigma (Stangl, A.L, 2019).

The findings would benefit a wide range of mental health professionals and others involved in care taking people with mental illness. The study would also help policy makers, communities and researchers to understand deep about community perception and stigma associated with people living with schizophrenia and to design policies , programmes and other interventions.

## Statement of the problem

The problem of the present study has been stated as “examination of societal perception and trust behaviour towards people living with schizophrenia”

## Operational definition of key terms

### Societal perception

In the present study, societal perception refers to the processes by which a person uses the behaviour of others to form opinions or make inferences about those individuals, particularly regarding their motives, attitudes, or values. (APA)

**Trust behaviour**

In the current study, Trust behaviour refers to all kind of meaningful behaviour which communicates that the interaction partner is perceived as a trustworthy actor. (Kasten, 2018)

**Stigma**

CAMI scores will be taken as stigma scores in the present study. Also scores of authoritarianism, benevolence, social restrictiveness and community mental health ideology scores will be taken as stigma scores according to AU, BE, SR, CMHI respectively.

**Healthy controls**

Individuals not having schizophrenia or other major psychotic illnesses

**Trust propensity**

Baseline score of investment made to 'human' in phase 1 of the task is taken as trust propensity scores

**Risk propensity**

Baseline score of investment made to 'lottery' in phase 1 of the task is taken as risk propensity scores

**Objectives of the study**

- To compare the investment made to people living with schizophrenia (PwSz) and healthy volunteers (Hv)
- To examine the effect of feedback on the investments made
- To compare the effect of feedback on the investment made to people living with schizophrenia (PwSz) and healthy volunteers (Hv)

- To examine the effect of trust on the investment made
- To compare the effect of trust on the investment made to people living with schizophrenia (PwSz) and healthy volunteers (Hv)
- To examine the impact of risk taking on the investment made
- To examine the relationship between investment made to people living with schizophrenia and their attitude towards mentally ill

**Hypothesis of the study**

- There is no significant relationship between the money invested by healthy individuals on people living with schizophrenia compared to healthy volunteers
- There is no significant difference between pre feedback investment made to people living with schizophrenia (PWSz) and healthy volunteers (Hv)
- There is no significant difference between post feedback investment made to people living with schizophrenia (PWSz) and healthy volunteers (Hv)
- There is no significant difference between the effect of trust on the investment made to people living with schizophrenia (PWSz) and healthy volunteers (Hv)
- There is no significant relationship between the investment made to people living with schizophrenia and the attitude towards mentally ill

# CHAPTER II

# REVIEW OF LITERATURE

A systematic examination of a body of data already in existence that identifies, assesses, and synthesises for clear presentation is referred to as a literature review (Fink, 2010). This chapter has been discussed under two major headings i.e. Theoretical Review and Empirical Review of literature. The theoretical review explores various conceptual frameworks and models of the variables and the empirical review entails various empirical studies conducted by other researchers which are related to the current research. Therefore, the existing literature has been reviewed to understand the concepts and associations of the variables interest.

Stigmas are of different types. Mainly it includes self-stigma, public stigma and structural stigma. (Corrigan, Powell, & Rusch, 2012). Among these types of stigma, for the purpose of current dissertation, Public stigma will be primarily discussed about. Public stigma is an external evaluation of someone else, which is based upon the norms of society (Overton & Medina, 2008).

## Theoretical review

Theoretical review provide a framework for organizing and advancing research on trust and stigma associated with mental illness. Even though there are many models explaining various types of stigma, the chapter deals primarily with various theoretical perspectives on public stigma.

## Public stigma

Three categories of stigma were put forth by Goffman (1963): “tribal identities” like race or ethnicity, “physical characteristics” like physical deformity, and “defects of character” like mental illness or addiction. When the stigmatising trait is apparent to others,

according to Goffman, these categories have unfavourable effects. The stigma associated with mental illness is normally kept hidden, although some extreme symptoms, such as disorganisation and reacting to auditory hallucinations, can make the disease known to others. Five conditions must be met, in accordance with Link and Phelan (2001), for there to be public stigma: the societal formation of unfavourable stereotypes about the stigmatised group, the sense of disparities between groups, and the segmentation of people into various groups that establish a "us versus them", discrimination and loss of status suffered by labelled members of the stigmatised group; and power imbalances (social, economic, or political) between the labelled group and those who assign it (Link & Phelan, 2001).

In terms of public stigma, the chapter discusses five theories: (1) modified labelling theory, (2) social-cognitive model, (3) stereotype content model, (4) implicit stigma, and (5) attribution theory.

**Table no 1**

***Theoretical review***

*Table 1*

| **Theory** | **Description** |
|---|---|
| Modified labeling theory (MLT) | According to the modified labelling hypothesis, individuals of a culture learn as part of their socialisation that mentally ill persons are beneath value and should be rejected. |
| Social cognitive model (SCM) | Deals with the three components of stigma are stereotype, prejudice and discrimination |
| Stereotype content model | All group stereotypes are shaped along two axes: (1) competence and (2) warmth |

| | |
|---|---|
| Implicit stigma theory | Argues that stigma arises from both automatic and intentional mental processes. |
| Attribution theory | Suggests that individuals tend to attribute negative stereotypes and labels to stigmatized groups based on their perceived causes of the stigma, leading to blame people with mental illness for being responsible for their condition. |

**Modified labelling theory**

Understanding the effects of stigma connected to psychiatric illnesses is facilitated by labelling theory. According to the labelling theory, people who belong to a majority group may see and label those who are members of a minority group as being outside of what is "normal," which will lower their value. Minority groups' perceptions of themselves and how they act in social contexts will be influenced by this sense of being classified as abnormal. Modified labelling theory (MLT), according to Link and colleagues (1989), explains how people come to have unfavourable attitudes towards those who have mental illnesses. Individuals learn about the social distinctions between themselves and the stigmatised person or group during the socialisation process within a particular culture (Link & Phelan, 2001). Once a person develops a mental illness, these attitudes become directly applicable to them, and they begin to anticipate social rejection and devaluation. They can then react in a number of ways: (1) keep their symptoms and diagnosis a secret; (2) avoid social settings where they risk being stigmatised; or (3) inform others about mental illness. Negative results may result from an individual's own assumptions about the views of the community, or they may result from actions taken to protect oneself, such as avoidant and isolative behaviour.

**Social cognitive theory**

A relevant framework for comprehending the causes and effects of internalised stigma is provided by social-cognitive theory (Bandura, 2001). The social cognitive model expands on the fundamental assumption of MLT to explain how thoughts, emotions, and behaviours relate to the spreading of stigma. As per SCM (social cognitive model), stereotype, prejudice, and discrimination are the three constructs that make up stigma (Sheehan et al., 2017). Public stigma develops through a cognitive-behavioural process in which thoughts influence feelings and actions. Stereotypes are the common generalisations about a group, thus are regarded as cognitive aspect.

The cognitive-behavioural process of mental illness is based on social indicators such eccentricity, the appearance of symptoms, or overt labelling. The stereotypes associated with that specific group are actually activated when a person is seen to be a member or potential member of a stigmatised group, which leads to prejudice and discrimination. (Snowden, 2022)

**Stereotype content model**

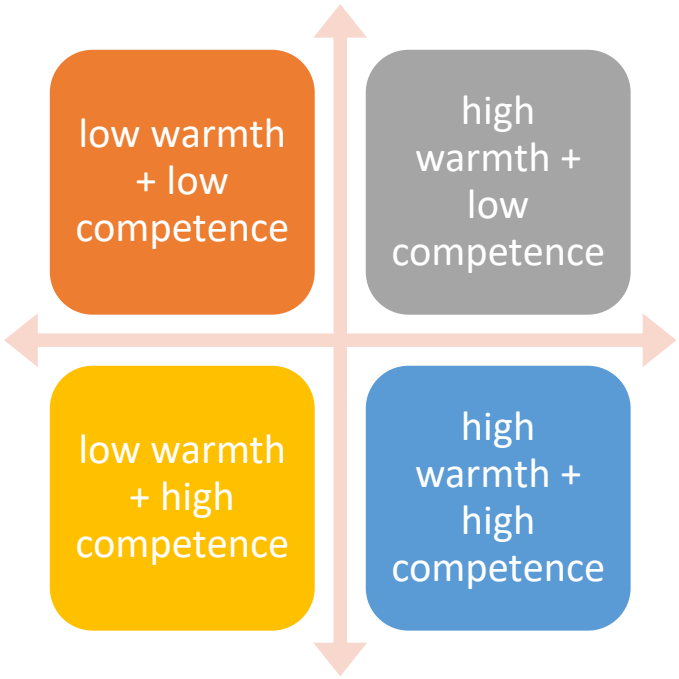


*Figure 1*

Fig 1 adapted from fiske,2018

According to the stereotype content model, which is an extension of the social cognitive method, people stereotype based on perceived warmth and competence of social groups (Fiske et al., 2002). The warmth-competence matrix divides stereotypes about groups into four categories: (1) low for warmth and low for competence; (2) high for warmth and competence; (3) low for warmth, high for competence; and (4) high for warmth, low for competence (Fiske, 2018). Consequently, stereotyped information about a social group causes either favourable or unfavourable attitudes towards its members. Groups with low warmth and competency inspire feelings of disdain, whereas groups with high warmth and competence inspire admiration. High-warmth and low-competence groups are frequently pitied, while the reverse is true for low-warmth and high-competence groups (Fiske, 2018). The elderly, individuals with impairments, and young children are seen as warm but inept groups. Rich people, businesspeople, and technical professionals are among the groups viewed as having low warmth but great competence.

According to different diagnoses, people with mental illness are regarded as being relatively lacking in warmth and competence (Boysen, 2017). People with mood problems are rated as having a moderate level of warmth and competence, whereas people living with schizophrenia are rated as having a low level of both. Studies using the stereotype content model have compared stereotypes of more feminine and more masculine mental health disorders, such as eating disorders and borderline personality disorder, and found that people with more masculine disorders are perceived as lacking warmth and competence (Boysen, 2017). Additionally, compared to feminine problems, masculine disorders evoke more unfavourable feelings and behavioural intentions (Boysen, 2017).

**Implicit stigma model**

The majority of studies on the stigma of mental illness have emphasised the intentionality and consciousness of stigma. The dual process approach, however, contends that stigma arises from both unintentional and intentional mental processes (Reeder & Pryor, 2008). Deliberate processing requires effort and control on the part of the brain, whereas automatic or implicit processing relies on mental heuristics like stereotypes to direct behaviour. Stereotypes may be automatically activated by social cues (such as a person's looks), and intentional processing is necessary to override first impressions. A conflict between emotional and behavioural responses can occasionally be the result of dual processing (Reeder & Pryor, 2008). If someone meets a person with schizophrenia, they might have an implicit fear response, yet they might still be kind to them. People tend to rely more on implicit processing in certain circumstances, such as those that are time-constrained or high-stress, but in other circumstances, there is an opportunity and motive for reflection and discussion about social groupings (Reeder & Pryor, 2008). People may not be aware of implicit bias, making it difficult

for them to accurately express their beliefs and feelings on self-report scales for prejudice or on other diagnostic tests meant to look into stigmatisation of people with a particular health condition (Mannarini & Boffo, 2014). As a result, the Implicit Association Test (Greenwald et al., 1998) is frequently used to assess implicit bias.

**Theory of attribution**

The theory of attribution is a helpful framework for analysing how stigma towards certain conditions has evolved. According to the attribution theory, the stigmatizer's reaction is based on the perceived source of the stigmatised identity (Weiner, 1995). Three aspects of the condition are described by the theory of attribution: (1) internal vs external locus of control, (2) stability of the cause of the condition, and (3) controllability. Higher amounts of stigma may be applied to those who are thought to be personally accountable for their condition. Additionally, Weiner (Reference Weiner 1995) distinguishes between onset and offset responsibility. Offset responsibility is the perceived capacity to manage recovery, as opposed to onset responsibility, which relates to the person's agency for the development of the condition or membership in a group (Sheehan et al., 2017). In the case if obesity, since the onset and offset responsibilities for it are higher than those for other health disorders, people with obesity may experience greater stigmatisation (Malterud & Ulriksen, 2011). Thus, people with mental illnesses may have intense feelings of guilt for their condition (Schomerus et al.,2014). The stigma surrounding mental illness appears to be reduced by biogenetic explanations for the illness (e.g., schizophrenia is a brain disease). These explanations seem to undermine the idea that the problem is solely the patient's fault. However, paradoxically, when people assume that because the aetiology is biological, recovery efforts are pointless, biogenetic attributions threaten to highlight differences between those with and without a

mental illness (e.g., their brain is just damaged) and to undermine potential for recovery (Kvaale et al., 2013). Paternalism and other stigmatising behaviours may increase as a result of prejudices based on biogenetic theories. As a result, attribution theory offers promising directions for investigation into public perceptions of the causes of the onset of mental disease as well as its rehabilitation.

**Theoretical perspectives on trust**

Interpersonal trust has been conceptualised in psychology in two main ways over the years. The majority of early research adopted a dispositional (person-centered) view of trust, which presupposed that it was reflected in an individual's overall attitudes, beliefs, and expectations about the degree to which other people tend to be dependable, cooperative, or helpful in various social contexts (e.g., Deutsch, 1973 ; Rotter, 1971 ). However, in the 1980s, concepts and measures of trust began to focus more on partners and relationships (e.g., Holmes & Rempel, 1989; Rempel et al., 1985).

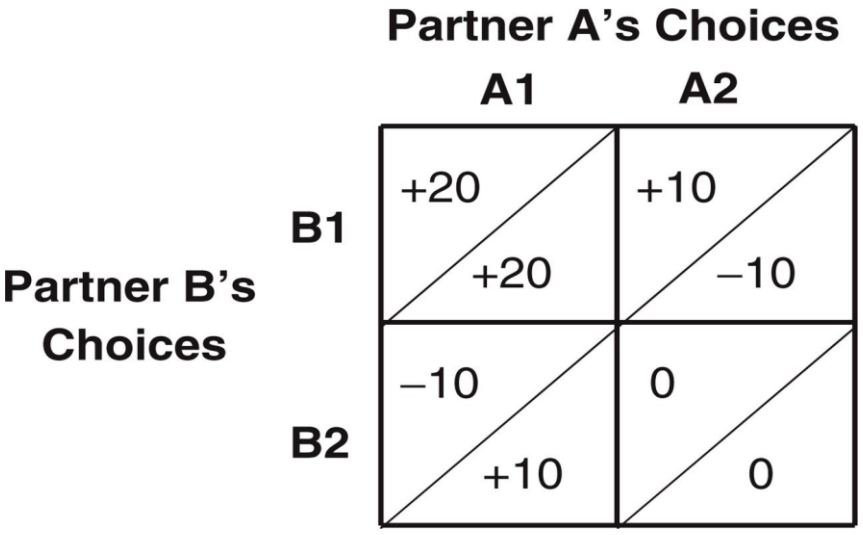


*Figure 2*

*Figure 2 adapted from Simpson, 2007*

This interpersonal (dyadic) viewpoint claims that trust represents the psychological orientation of an actor (the truster) towards a particular partner (the trustee), from whom the actor is somewhat interdependent (the truster needs the trustee's assistance to achieve valued things).

The fact that trust has three components (for instance, "I trust you to do X"; Hardin, 2003) makes it difficult to study. To put it another way, trust is based on the characteristics of the self (I), the specific partner (you), and the situation (to do X).

According to Kramer and Carnevale (2001), trust requires a set of expectations, beliefs, and attributions that a partner will act in one's best interests consistently over time, particularly in circumstances where a person must rely on their partner to achieve significant goals and outcomes. These trust-relevant circumstances frequently trigger two psychological processes: feelings of vulnerability and a foresight into the partner's behaviour.

Both partners, but especially the one who benefits, should trust one another more when one partner constantly encourages and makes possible what is best for a person instead of what is best for them. Additionally, trust should be higher when both partners' self-interested goals closely coincide with those that are best for their relationship and/or when both people have faith in their partner to act in the relationship's best interests, even when those goals conflict.

By applying concepts from interdependence theory, Kelley and his colleagues (2003) suggest that it is possible to determine a partner's appropriate level of trust more precisely in some circumstances, particularly in situations where trust is at stake. Trust-relevant situations typically involve high levels of interdependence (i.e., each partner's thoughts, feelings, and actions are significantly influenced by the other), a combination of rules that

encourage coordination and exchange (which maintains interdependence between partners in the relationship), and partners experiencing moderately corresponding (i.e., similar) internal states. (Kelley et al., 2003). These situations also include the "stag hunt" and "assurance" experimental paradigms within game theory. The figure shown above depicts an example of a trust-relevant circumstance that has been studied in the psychological literature. When partners in a relationship consistently choose A1/B1 (i.e., decisions that are mutually beneficial and yield the greatest return for both parties), trust is likely to grow.

Partner A receives payouts in each cell above the diagonal, while Partner B receives payouts below the diagonal. Each partner gains units of benefit if both partners choose Option 1 (e.g., they work together on a challenging but crucial assignment, depicted in the A1/B1 cell) since the task is completed and couples get to spend time together. Both partners lose out since nothing is done if both partners choose option 2 (neither partner works on the task, which is represented by the A2/B2 cell). If partner A picks option (2) (not to work on the assignment A2), but partner B chooses option (1) (works alone on the task B1), partner A gains 10 units since the task advances, while partner B loses 10 units because they have to complete the task alone. When partner A decides to work on the assignment and partner B decides to not work on it, the pattern is reversed. Most trust-relevant circumstances have three distinct characteristics. In the first place, when both partners cooperate (A1/B1), the results are always better than when they don't (A1/B2 or A2/B1).

Second, the finest results are always achieved when both partners choose in concert (A1/B1). Third, choosing a cooperative decision comes with risk; if one's partner doesn't cooperate, doing so results in the worst outcomes for the exploited person. The majority of empirical research on trust conducted to far in the psychological literature has been motivated by interpersonal or dispositional approaches.

People who are more insecurely connected or who have lower self-esteem tend to trust their relationship partners less on average, according to a large body of dispositionally oriented research ( Simpson, 2007). Most research on interpersonal relationships has shown that people are more likely to trust someone they feel is devoted to the relationship, has their best interests in mind, and has pro-relationship objectives and motivations. Additionally, trust tends to increase when partners show pro-relationship transformations of motivation, which is when they turn their original negative emotions towards their partners' potentially detrimental actions into positive responses that help their partner or the relationship. These altered responses frequently lead to self-sacrificing or accommodating behaviours that help to uphold or strengthen the connection. In addition, the process of building trust frequently entails a reduction in uncertainty whereby people move from having confidence in their partner's general predictability (e.g., "I know what my partner will do in this situation") to having confidence in their partner's pro-relationship values, motives, goals, and intentions (e.g., "I know that my partner will do what's best for me and/or our relationship in this situation"; Holmes & Rempel, 1989 ).

A number of these key principles of interpersonal trust derive from the study mentioned above. They have been discovered in recent, comprehensive reviews of the literature on interpersonal trust in psychology (Dunning et al., 2009; Simpson, 2007;and Van Lange 2015).

- Trust grows mostly as a result of social interactions, particularly those with people in one's social networks and media exposure.
- Regulating, observing, and altering how much trust we place in others is adaptive.
- Although people often underestimate how trustworthy others are, they do report being willing to trust people, even strangers, at least initially ( Dunning et al. 2019).

- People gauge how much they can trust their partners by monitoring whether they exhibit a change in motivation in trust diagnostic situations, such as in trust-relevant, stag-hunt, or strain-test scenarios when partners can choose to act against their own interests and in the relationship's or partner's best interests.
- People may engage or manufacture trust-diagnostic situations, despite the fact that they sporadically arise in regular life, to determine whether their degree of confidence in their partner is justified.
- Relationships can experience changes in trust over time due to individual differences such as attachment security versus insecurity and high versus low self-esteem, among other factors. People with stronger attachments or higher self-esteem, for instance, frequently report higher levels of trust and gains in trust in their relationships.
- Without taking into account the disposition and behaviours of both relationship partners, it is impossible to properly comprehend the level and trajectory of trust in partnerships. (Simpson, 2022)

**The Dyadic Model of Relational Trust**

*Figure.3 Depicts dyadic model (adapted from Simpson, 2007)*

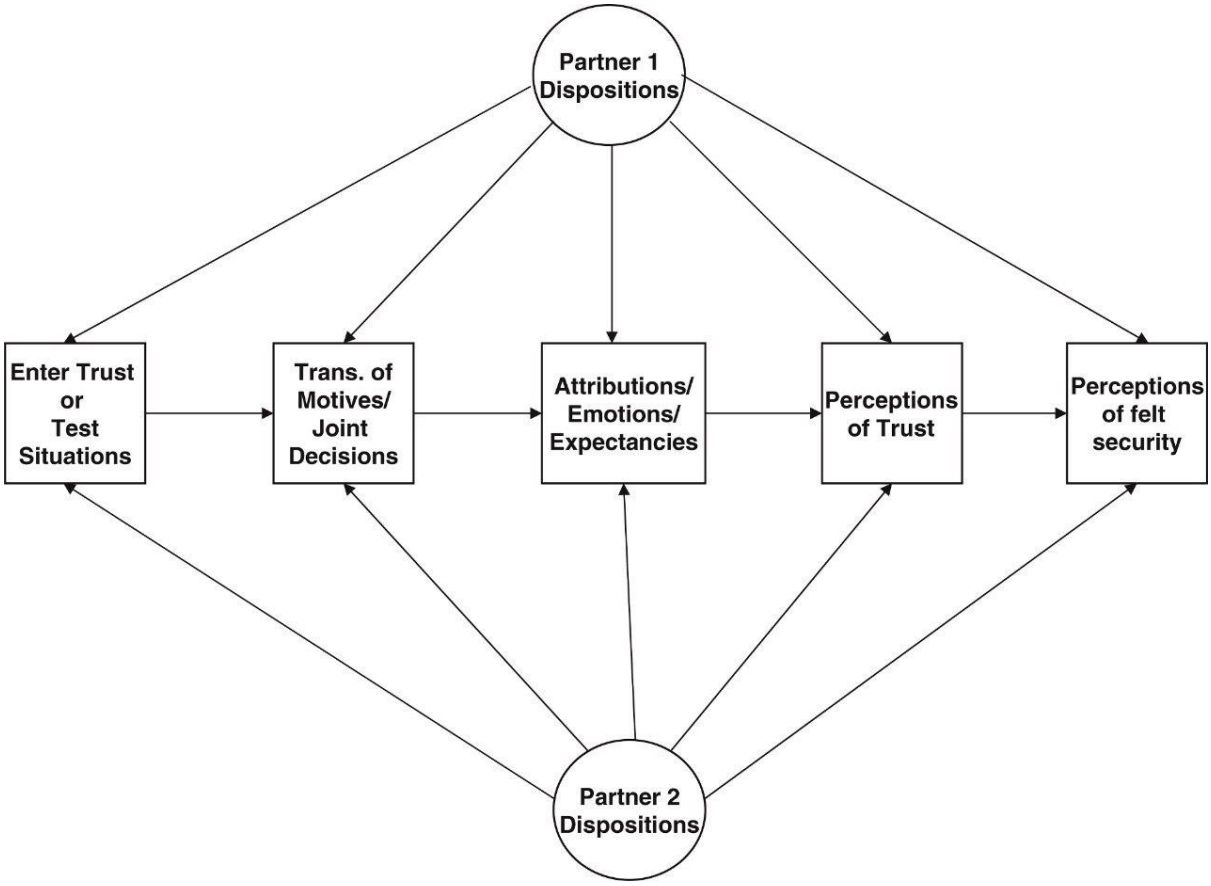


*Figure 3*

The normative components (shown in the boxes in the middle of the figure) and the individual difference components (represented at the top and bottom of the figure) make up the two major parts of the dyadic model of trust in relationships (Simpson, 2007). The individual difference components provide the trust-relevant personality traits of each relationship partner, including their attachment preferences, self-esteem, and correlations with the model's normative constructs. The model on the far right assumes that feedback loops exist between the constructs that launch the next interaction—each partner's choice to enter the next situation involving trust—and the terminal construct—each partner's level of felt security following an interaction with their partner. The model suggests that each partner's responses to each of the downstream constructs in the model are partially explained by their views of their own and their partner's position on each construct.

The model further posits that understanding the development of trust (or lack of it) in a relationship over a number of encounters requires knowledge about the dispositions of both partners that are relevant to trust.

The aforementioned dispositional characteristics should encourage or empower people to engage in, change, and occasionally produce social encounters that, over time, either build or diminish trust. Two types of situations provide opportunity to measure the amount of trust in a relationship (1) *trust relevant situations* (Kelley et al., 2003) where partners repeatedly make (or fail to make) mutually beneficial A1/B1 decisions and ( 2) *strain test situation* (Holmes, 1981), where partners show (or not show) their willingness to make personal sacrifices for the benefit of the relationship. However, one or both partners must have enough confidence to take the interpersonal risks necessary to confirm or reaffirm that their relationship is trustworthy before these *trust-diagnostic situations* are entered, modified, or generated. Positive working models, such as those who have strong self-esteem or are firmly attached, should be more willing to take these interpersonal risks than negative working models (i.e., those who have positive ideas and expectations about themselves and their romantic partners).

People who are willing to make choices that benefit their partners or relationship at the expense of themselves should feel more trusted and secure once they are in trust-diagnostic scenarios. Additionally, partners who have effective role models should exhibit partner- or relationship-based motivational changes more frequently and comprehensively. They ought to be better competent and motivated to direct trust-relevant social interactions towards choices and results that will benefit both parties. Working models should have an impact on how people view how much change they and their partner have gone through after these choices have been made. Comparatively to individuals who have negative working models, people who have positive working models frequently give themselves and their

partners more credit for each partner's readiness to prioritise partner and/or relationship goals and objectives over personal goals and outcomes. (Murray et al., 2006)

Figure depicts patterns of attributions, emotion control, and situation-specific expectancies in a single box because the temporal order of these processes may vary depending on the particulars of a given interaction, each partner's working models, and/or the peculiar norms or traits of their relationship. Collectively, these favourable results ought to maintain or boost views of trust, which should at least momentarily boost the feeling of security. This should then prepare the subsequent trust-relevant interaction, influencing whether, when, and how it is brought into being, altered, or created.

People frequently put themselves in trust-relevant or strain-testing circumstances without intending to or consciously striving to do so. However, when significant, unexpected, or suspicious circumstances make people wonder if they can continue to trust their partners, purposeful attempts to enter or create these situations ought to be made. Even though these encounters might be quite diagnostic, planned “tests” are probably not done very frequently because of the risk they could represent to the majority of relationships.

Partners who consistently achieve mutually beneficial results should over time perceive more "added value" as a result of their pro-relationship decisions, particularly in instances where trust is being assessed. These recurring successes are likely to motivate both parties to carry on with relationship-maintaining or relationship-building behaviours (such as disparaging attractive alternative partners or viewing the partner favourably), which should support or facilitate mutually advantageous choices and actions.

However, if one or both partners have negative working models, choose not to come to a mutually beneficial agreement, or harbour negative perceptions of their partner’s relationship-relevant objectives and motivations, these impacts should lessen.

**Trusting strangers**

Recent research on interpersonal trust and trust in strangers gives information on the circumstances and traits of strangers that help or hinder the growth of trust. Research using trust games (TG) has helped us understand how trust works at a more distal level (Johnson & Mislin, 2011).

Expressing concern or care about divisive social topics is just one of the many ways that one can convey their trustworthiness. People are more likely to trust persons who care about significant social issues than those who do not, according to a number of studies. Particularly in the case of integrity-based trust. Furthermore, people are more likely to trust those who disagree with them on social issues than those who do not (Zlatev, 2019 ). In other studies, trust levels have been measured using traits of the person who is trusting rather than traits of a stranger. For instance, those with a high Big personality characteristic score of openness to experience are more likely to have faith in individuals from different cultural backgrounds (Saef et al.,2019). Additionally, older persons are regarded as being more trustworthy and have a tendency to trust experimental TGs more (Greiner & Zednik, 2019).

According to Van Lange et al. (2014), compared to other categories like various personality traits and cognitive talents, generalised trust in oneself and others has lower genetic underpinnings. This is in line with earlier ideas that contend that interpersonal processes that support or undermine working models (i.e., cognitive schemas linked with trust) play a key role in the development and maintenance of trust. But the emergence of trust can also be influenced by personal characteristics and environmental factors.

For instance, adult trust levels have been connected to childhood socioeconomic status (SES) (Stamos et al.,2019). According to Stamos and colleagues, the

relationship between childhood SES and adult trust may be partially explained by the life history theory.

According to the life history hypothesis (Del Giudice et al., 2016; Simpson & Belsky, 2016), individual differences arise during the course of a person's life as they make trade-offs based on the resources that are accessible to them.

People who are raised in homes with lower SES may face more threats, which typically causes them to become more hyperaware of their surroundings and wary of people in general. Social trust is also correlated with income inequality and life happiness inequality, with the relationship between the two being mediated by life satisfaction inequality (Graafland & Lous, 2019). These studies show that people's ability to establish trust in other people, especially strangers, depends on both the surroundings in which they are born and the ones in which they currently live.

Finally, the minimal engagement that people have with strangers also influences how much trust they have in them. Through the conduct of the stranger during such exchanges, trust may be influenced, which may make the trustee uneasy. Sharing information with strangers is one way they might become more trustworthy. For instance, people often feel more trusting of the person who confided in them after hearing an amusing piece of gossip. But one's perception of the discloser's reliability is also influenced by how accurate the information is that is given. Although more inaccurate information hinders the development of trust, providing limited amounts of inaccurate information seems to increase trust more than providing no information at all (Fonseca & Peter's, 2018 ). The converse is also true: those who trust others more are frequently better at spotting lies than those who do not (Carter & Weber, 2010). This does not mean that persons who trust strangers are more prone to deception.

**Empirical Review**

*Table 2*

| **Authors** | **Year** | **Region** | **Method-ology** | **Major findings** |
|---|---|---|---|---|
| Venkatesh, B., Andrews, T., Mayya, S., Singh, M., & Parsekar, S. | 2015 | South India | Cross sectional study | The prevalence of stigma towards people with mental illnesses was 74.61% from a total of 445 respondents (95% confidence interval, 0.7057, 0.7866). All four CAMI scale domains showed a high incidence of stigma. Higher income earners and females were more likely to experience bias. It was also noted that towards people living with mental illness, stigma was widespread. The stigma towards people living with mental illness was associated with gender with respect to authoritarianism, benevolence , and community mental health ideology subscales of CAMI. |
| Hartini, N., Fardana, N. A., Ariana, A. D., & Wardana, N. D. | 2022 | East java | Survey study | The findings of the study suggest a weak negative correlation between age and stigma towards individuals with mental illness. Also, there were no significant differences in stigma levels observed among different education groups. |

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|---|---|---|---|---|
| Simões de Almeida, R., Trigueiro, M. J., Portugal, P., de Sousa, S., Simões-Silva, V., Campos, F., Silva, M., & Marques, A. | 2023 | Portugal | Cross sectional study | The study found that older individuals exhibited higher levels of stigma towards individuals with mental health problems. On the other hand, higher levels of education were associated with lower levels of stigma and also younger women displayed significantly lower levels of stigma compared to other demographic groups. |
| Venkatesh, B., Andrews, T., Mayya, S., Singh, M., & Parsekar, S. | 2015 | South India | Cross sectional study | Out of 445 participants surveyed, approximately 74.61% were found to have a stigma towards individuals with mental illness. Stigma was found to be prevalent across all four domains of the CAMI scale. Furthermore, females and individuals with higher income displayed a higher prevalence of stigma. |
| Koschorke, M., Padmavati, R., Kumar, S., Cohen, A., Weiss, H. A., Chatterjee, S., Pereira, J., | 2014 | India | Mixed methods design | The results reveal that instances of direct negative discrimination were reported less frequently, accounting for 42% of the responses. In contrast, internalized forms of stigma, such as feelings of alienation, were more commonly experienced, with 79% of respondents reporting such sentiments. Additionally, the occurrence of negative discrimination in this study was found to be |

| | | | | |
|---|---|---|---|---|
| Naik, S., John, S., Dabholkar, H., Balaji, M., Chavan, A., Varghese, M., Thara, R., Thornicroft, G., & Patel, V. | | | | significantly lower compared to similar studies conducted in other locations. Higher levels of positive symptoms of schizophrenia were identified as a predictor of experiencing negative discrimination. |
| Boti, Hussen, Ayele, Mersha, Gebeyehu, Feleke, and Temesgen | | Ethiopia | Cross sectional study | about one-third of inhabitants held negative opinions about people living with schizophrenia.<br>55.9% believed substance misuse was a predisposing factor for schizophrenia<br>39.4% agreed with hospitalization for individuals displaying schizophrenia indicators<br>70.5% viewed persons with schizophrenia as potentially hazardous. |

A cross-sectional, community-based study with 445 participants from the Udupi area was conducted by Venkatesh, B., Andrews, T., Mayya, S., Singh, M., & Parsekar, S in 2015, to assess stigma. By using the cluster sampling technique, data were gathered from wards in rural and urban areas, which were then considered as clusters. The 10 wards/blocks of the Udupi district were chosen using the probability proportional to sampling size technique, and the sample size from each ward/block was determined using proportional allocation based on

the ward/block's population size. Data were gathered by conducting house-to-house interviews with one participant chosen from each family, and convenience sampling was utilised to choose households from each ward/block. The data were gathered via an anonymous, semi-structured questionnaire. Community Attitude towards Mentally Ill (CAMI) scale was also used. The Chi-square test was used to determine whether stigma and other characteristics were related.

The prevalence of stigma towards people with mental illnesses was 74.61% among the 445 total respondents (95% confidence interval, 0.7057, 0.7866). All four CAMI scale domains - authoritarianism (AU), benevolence (BE), community mental health ideology (CMHI), social restrictiveness(SR) showed a high incidence of stigma. Higher income earners and females were more likely to experience bias. The prevalence of stigma against person with mental illness (PWMI) as a whole was found to be considerable. For AU, BE, and CMHI, the stigma against PWMI was related to gender.

A survey study in 2022 conducted in East Java with 1,269 participants by Hartini, N., Fardana, N. A., Ariana, A. D., & Wardana, N. D. Instruments included the Community Attitudes towards Mental Illness (CAMI) questionnaire, the Mental Health Knowledge Schedule (MAKS), and a sociodemographic survey. Results indicate that increased knowledge about mental health correlated with reduced stigma towards individuals with mental disorders. Furthermore, differences in stigma were noted across various factors, such as age, gender, contact experience, history of mental disorder, attitude towards pasung, marital status, and income level.

A cross sectional study conducted in 2015 by Venkatesh, B., Andrews, T., Mayya, S., Singh, M., & Parsekar, S in south India indicated that individuals in the older age bracket tend to display a greater degree of stigma towards those dealing with mental health issues. Conversely, individuals who have received a higher level of education are inclined to

exhibit less stigma in relation to these matters. Furthermore, it was observed that among various demographic segments, younger women exhibited notably diminished levels of stigma compared to their counterparts.

A mixed method research conducted in 2014 in India by Koschorke, M., Padmavati, R., Kumar, S., Cohen, A., Weiss, H. A., Chatterjee, S., Pereira, J., Naik, S., John, S., Dabholkar, H., Balaji, M., Chavan, A., Varghese, M., Thara, R., Thornicroft, G., & Patel, V. The study aims to outline the experiences and drivers of stigma as reported by primary caregivers responsible for individuals living with schizophrenia (PLS) in India. The research employed a combination of quantitative and qualitative methods, nested within a randomized controlled trial focused on community care for individuals with schizophrenia. From November 2009 to October 2010, information about caregiver stigma and functional outcomes was gathered from a sample of 282 pairs consisting of PLS and caregivers. Additionally, in-depth interviews were conducted with 36 caregivers.

Quantitative results revealed that a notable minority of caregivers (21%) reported experiencing 'high caregiver stigma'. A significant portion of caregivers also expressed discomfort in revealing the mental health condition of their family member (45%). The extent of caregiver stigma was independently linked to higher levels of positive schizophrenia symptoms, greater disability levels, younger age of the individual with schizophrenia, household education at the secondary school level, and the specific research site. Interestingly, the level of knowledge about schizophrenia did not appear to have a direct impact on caregiver stigma.

Qualitative insights illuminated the diverse ways in which stigma influenced the lives of family caregivers. These insights revealed connections between themes related to

caregiver stigma ('disclosure concerns', 'negative responses', and 'adverse emotions and self-perception') and other overarching themes within the data. The study findings underscore the necessity for interventions that cater to the needs of both individuals with schizophrenia and their family caregivers. The qualitative data also underscored the complexities underlying the relationship between knowledge and stigma, suggesting that imparting 'knowledge about schizophrenia' could potentially affect the stigmatization process in both positive and negative ways. The research proposes that educational interventions should consider context-specific factors when deciding on anti-stigma messages to convey. The results advocate for messages emphasizing concepts like 'recovery is attainable' and 'no one is at fault', as these might offer more constructive outcomes than solely focusing on biomedical knowledge.

Boti, Hussen, Ayele, Mersha, Gebeyehu, Feleke, and Temesgen, conducted a cross sectional study in Ethiopia and found that about one-third of the inhabitants had negative opinions of people living with schizophrenia. Over half (55.9%) of respondents believed that substance misuse was a predisposing factor for schizophrenia, and 233 respondents (39.4%) agreed that someone should be admitted to the hospital after showing indicators of schizophrenia. Nearly one-fourth (22.4%) concur that, with the right care, people living with schizophrenia can live freely in society. Nearly half (49.1%) of respondents concur that people living with schizophrenia are just unmotivated, weak-willed people. The majority of respondents (70.5%) concur that persons with schizophrenia are hazardous, and nearly half (49.4%) disagreed that people living with schizophrenia should change their behaviour and mental patterns instead of getting treated with medication.

As no study previously examined the trust behaviour towards people living with schizophrenia, there are no empirical studies on the same.

# CHAPTER III

# METHOD

## Research design

A research design is a plan, a roadmap and a blueprint strategy of investigation conceived so as to obtain answers to research questions, it is the heart of any study (kothari, 2004). Accordingly, considering the purpose and nature of the study, cross sectional observational design was found to be appropriate. Cross sectional observational study is a type of observational study in which exposure and outcome are simultaneously analysed. For collecting data from healthy volunteers, purposive sampling method was opted.

## Sample

A total of 50 healthy volunteers with a mean age of 31.92 years were recruited using purposive sampling method from Trivandrum and Kollam districts of Kerala. The sample consisted of 31 female (62%) and 19 male participants (38%). In the respective sample, the age of healthy volunteers ranged from 18 years to 50 years. 28 participants were from urban residence and 22 from rural residence. Furthermore, the participants also differed in their educational background, 13 from professional background, 13 post graduates , 9 high schoolers, 9 graduates, 4 diploma and 2 middle schoolers.

Inclusion criteria for healthy volunteers:

- Absence of lifetime axis-I diagnosis
- Age 18 years to 50 years
- Minimum education of 7 years

Participants between the age of 18 to 50 years with absence of lifetime axis 1 diagnosis and with minimum education of seven years were included.

Exclusion criteria for healthy volunteers:

- Subjects having serious medical illness which may interfere with the assessments
- Hindi Mental Status Examination score less than 24
- History of Intellectual disability disorder
- Family history of psychotic disorders in first-degree relatives

It was decided to exclude participants with serious mental illness or who score below 24 on HMSE Hindi Mental Status Examination scale or individuals with intellectual disability disorder as the study is being conducted on healthy volunteers. Also the study excludes individuals with family history of psychotic disorders in first degree relatives. The rationale behind this exclusion is the exposure and the subsequent change in attitude and perception towards mentally ill as a result of close contact with the patients.

Figure 4 *healthy volunteer participants by gender*

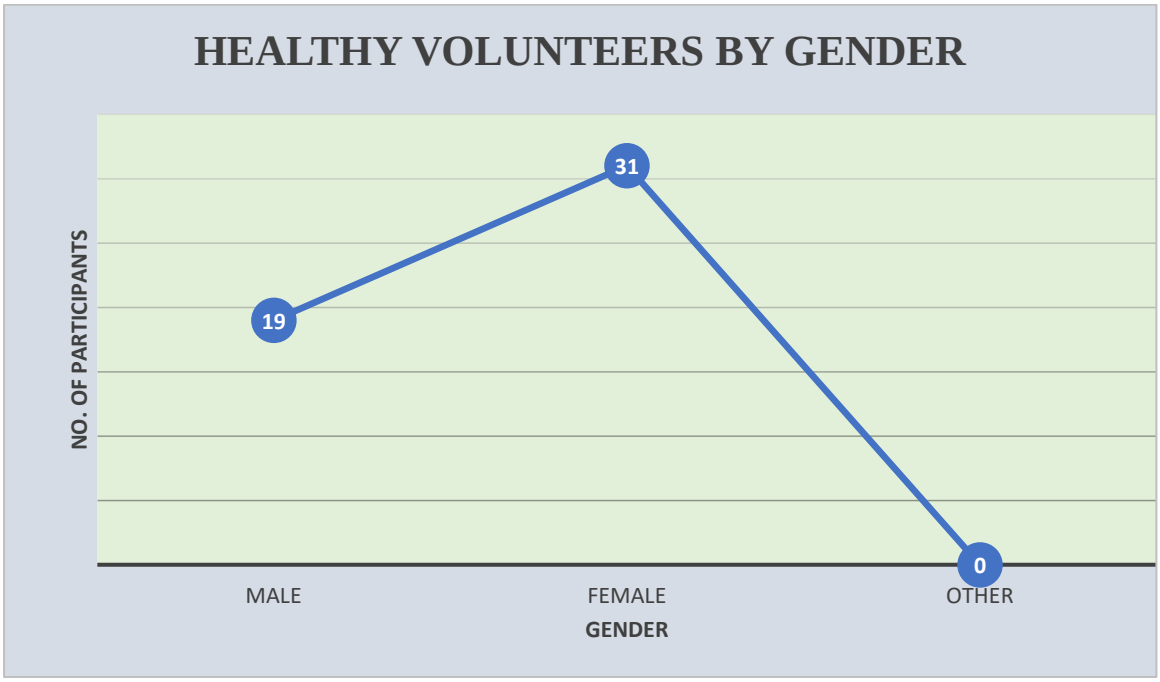



*Figure 4*

The sample for the present study included 19 male healthy volunteers and 31 female healthy volunteers chosen from Trivandrum and  Kollam districts of Kerala.

Figure 5 *healthy volunteer participants by residence*

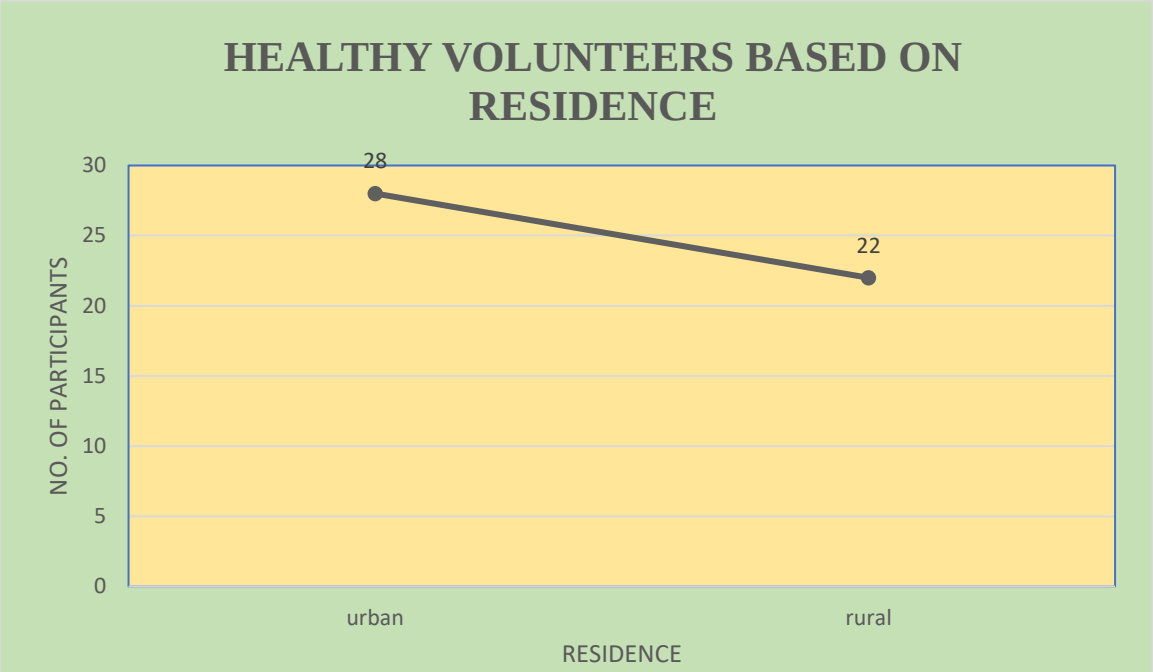



*Figure 5*

The present study sample consists of 28 participants from urban and 22 participants from rural residence chosen from Trivandrum and kollam districts of kerala.

*Figure 6 healthy volunteer participants by educational qualification*

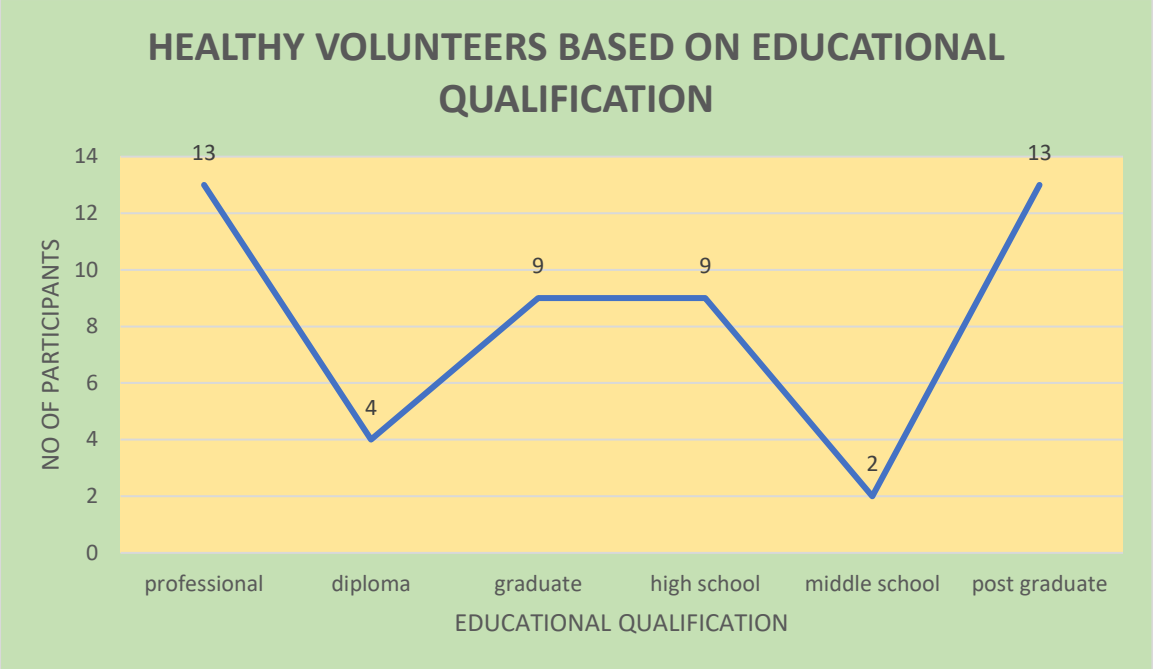



*Figure 6*

The present study sample comprises of various healthy volunteers from different educational background. 13 from professional background, 4 from diploma, 9 high schoolers , 9 graduates, 2 middle schoolers and 13 post graduates from Trivandrum and Kollam districts of Kerala.

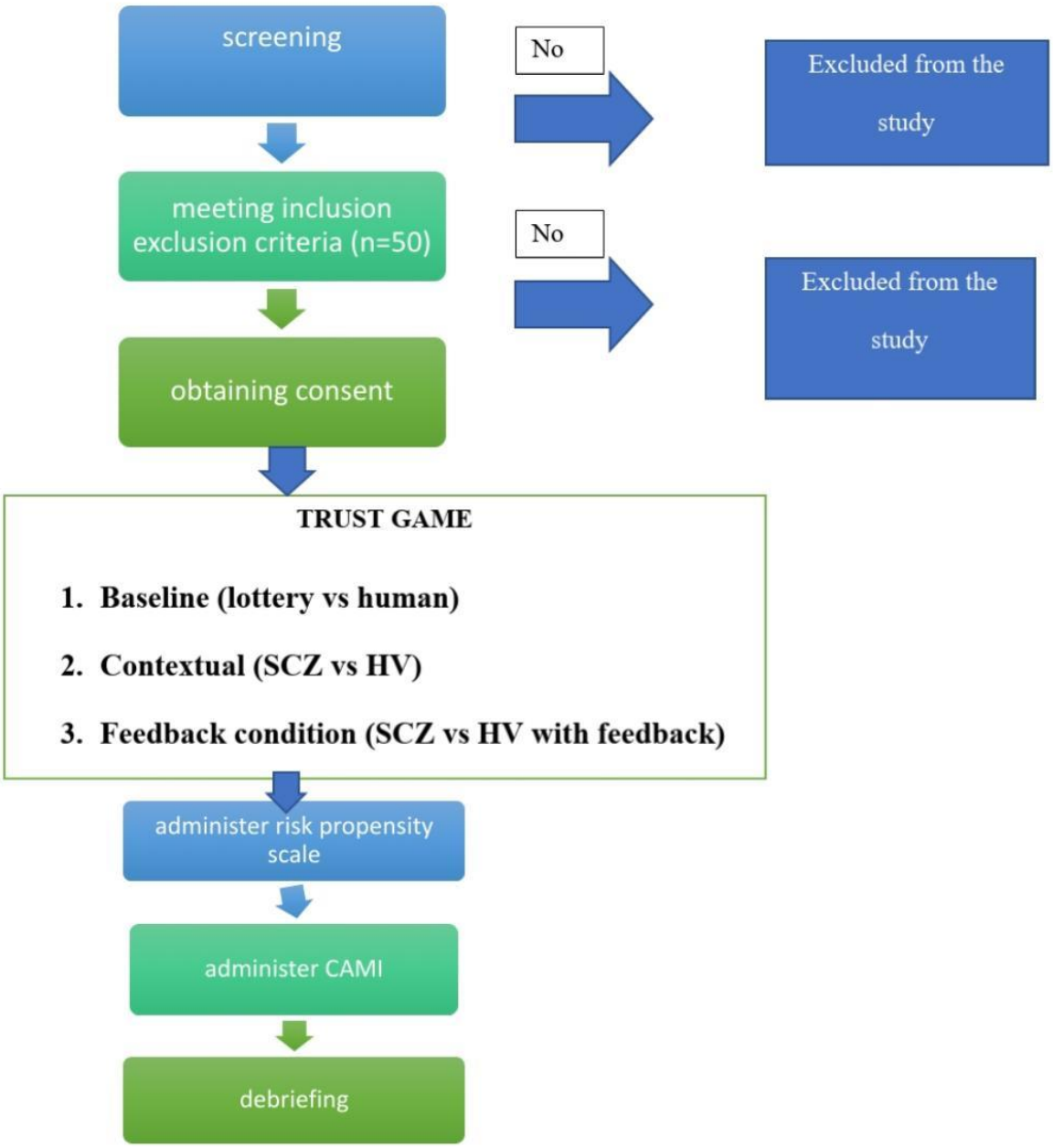
**Procedure**

Upon arrival, participants were seated and provided with a comprehensive overview of the study's duration and content. Ensuring confidentiality, informed consent was secured. Initial inquiries addressed any history of serious mental illness or psychotic conditions within their families. Subsequently, demographic information was collected. Further evaluation involved the application of the HMSE (Hindi Mental Status Examination) scale to exclude those displaying global cognitive decline (HMSE score < 24). Following this, participants underwent psychological distress assessment using the K10 scale. Successful candidates then engaged in the digit symbol substitution test, entailing the substitution of symbols for given digits within a 90-second timeframe.

The subsequent phase comprised the trust game, featuring three levels: baseline (involving lottery and human trials), contextual (involving participants with schizophrenia [SCZ] and healthy individuals [HV]), and feedback. Participants were informed that they would interact with real counterparts, yet, in reality, the computer provided predetermined responses. After completing level 1, participants proceeded to level 2, involving interactions with both individuals with schizophrenia and healthy individuals, denoted by red and blue symbols, respectively, over 20 randomized trials. For level 3, the same counterparts were involved, with feedback provided after half of the trials. All fundamental rules remained consistent across levels. Subsequent to task completion, risk propensity assessment and the Community Attitude Towards Mental Illness (CAMI) scale were administered. Post data collection, a debriefing session gathered participant feedback and provided a comprehensive explanation of the task's nature.

**Figure 7**

**Flow chart depicting the procedure of the study**



**Instruments used for data collection**

**Variables**: the variables in the current study are societal perception and trust behaviour.

In the present study trust game and standardized questionnaires were used to assess trust behaviour and societal perception. A number of studies have statistically analysed the tools used for data collection to corroborate the validity and reliability.

The following tools were used to collect data

1. **Socio-demographic data collected using a semi-structured proforma**

   Socio demographic data I. e., gender, age, place of residence, socio economic status, educational qualification, occupation, etc. of the participants were collected using a semi structured proforma prepared by the researcher.

2. **HMSE: Hindi Mental Status Examination for screening global cognitive decline**

   The Hindi Mental Status Examination (HMSE), a widely acknowledged test created by Mary Ganguli and Graham Ratcliffe in 1995 as part of an Indo-U.S. Project, mainly to eliminate linguistic and educational bias while assessing rural elderly illiterates for cognitive impairment in India. was used to evaluate global cognitive impairment. [Tsolaki, m, 2000, Ganguli, M, 1995]. Lower scores on the HMSE indicate severe cognitive impairment, making it one of the most popular screening tools for cognitive impairment. To determine the total level of each patient's current cognitive functioning, it was administered directly to them. The HMSE assessment takes roughly 10 minutes to complete. The scale was used in the current study to rule out individuals with cognitive decline.

   **Reliability and validity**

The HMSE scale has High sensitivity (0.81) and specificity (0.60).(Pandav R, Fillenbaum G, Ratcliff G, Dodge H, Ganguli M, 2002) This test was utilised in the study's pilot phase only to determine whether the MMSE and the HMSE were applicable to urban senior people in India, and it was found to have a strong correlation (r = 0.86) with MMSE scores for literate elderly people.(Tiwari SC, Tripathi RK, Kumar A, 2009)

**Scoring**

The total score of HMSE scale is 30 and the scores categorises participants into five categories. The scores ranging between 25 to 30 is categorized as normal cognition, mild cognitive impairment if the score range falls between 20 and 25, moderate cognitive impairment if score range falls between 10 and 20, and severe cognitive impairment if falls below 10.

3. **Risk propensity scale**

The risk propensity scale was developed by Meertens and Lion and in measures ones general risk taking tendencies. It is a short, nine item scale and rated on a nine point scale. Higher the score, higher the risk taking tendencies.

**Scoring**

The risk propensity scale has 9 items. With the exception of the final statement, which was scored on a scale from 1 (risk avoider) to 9 (risk seeker) (Weigold & Schlenker, 1991), all statements were rated on a 9-point scale ranging from 1 (completely disagree) to 9 (absolutely agree). Items 1, 2, 3, and 4 were rated in reverse order to gauge respondents' propensity for taking risks. Higher RPS scores are indicative of a greater propensity for taking risks.

**Reliability and validity**

Risk propensity scale has Cronbach's alpha value of about 0.77 indicating good internal reliability and test retest reliability. (Meertens, M , Lions,R, 2008)

**4. Community attitude towards mental illness (CAMI 12 item version)**

The 12-item scale adapted from the original Community Attitudes towards the Mentally Ill (CAMI) scale created by Taylor and Dear was used to measure attitudes about mental illness (Taylor sm, dear, M J, 1981). The CAMI-12 scale was initially used in the survey evaluating the Time to Change social marketing campaign. It is a subset of the original statements that was chosen to demonstrate degrees of tolerance and stigma connected to mental health. In the present study it was used to assess healthy volunteers in community attitude and public stigma towards mentally ill.

**Scoring**

On a five-point Likert scale, each item is assessed (1 = strongly agree, 5 = strongly disagree). Items with negative statements underwent reverse recoding for analysis. It has four subscales Authoritarianism, Benevolence, Social Restrictiveness, and Community Mental Health Ideology.

Authoritarianism refers to a "view of the mentally ill person as someone who is inferior and requires supervision and coercion." Benevolence means "a humanistic and sympathetic view of mentally ill persons", social restrictiveness refers to "the belief that mentally ill patients are a threat to society and should be avoided." Community Mental Health Ideology means "the acceptance of mental health services and the

integration of mentally ill patients in the community" (Taylor sm, dear, M J, 1981). Higher authoritarian and community mental health ideology scores indicate higher stigma and lower benevolence and social restrictiveness scores corresponds to lower stigma. By summing up all the four subscales total stigma was calculated. Higher the scores, lesser the stigma towards people with mental illness.

**Reliability and validity**

5. **Digit Symbol Substitution Test DSST**

The DSST – Digit Symbol Substitution Test measure visuo-motor coordination, motor persistence, sustained attention and response speed (Lezak, 1995). The test consists of four rows with a total of 100 little blank squares, each paired with a number from 1 to 9, that has been chosen at random. At the top of each rows is a written key that matches each number with a unique nonsense symbol. The participant is given 90 seconds and told to fill in the blanks as rapidly as they can with the symbol that matches the number above the blank spot. The test has been standardised for Indian population (Rao et al., 2004).

**Reliability and Validity**

which is in the expected range for internal consistency i.e., greater than 0.60.

6. **Trust Game**

Trust game is a neuro cognitive game( Berg et al 1995) which measures trust, trustworthiness or reciprocity. In the Trust game, the "Investor" has a certain amount of money bestowed to them, and they can choose to transmit all, some, or none of it to the "Trustee." Before each unit reaches the Trustee, who chooses whether to refund all, some, or none of the money received

to the Investor, it is multiplied by the experimenter (often by three). The Investor could earn more by investing, but they risk losing more if the Trustee "defects" and retains the money, rather than "reciprocating" and returning part of the multiplied investment. To maximise income, the Investor should not share any of their endowment and the Trustee should not return any of what they are given. However, practically all Investors send some money—typically 50% of their endowment—and Trustees reimburse them for roughly the same amount. (Wischniewski et al 2009, Camerer et al 2004, Berg et al 1995, McClintock et al 1966)

According to a review of the neuroscience underlying the Trust Game, different brain regions are involved at different stages: deciding what to send or return involves frontal areas; determining the outcome activates reward circuitry, evaluation mechanisms, and emotion-processing regions (tzieropoulos, 2013). A cortical and subcortical network is also implicated in decisions about trustworthiness. The anterior insula is engaged during decisions of whether to trust in single-shot games, suggesting an aversion to uncertainty, according to a meta-analysis of fMRI studies (Bellucci, 2017). During multiple-shot games, the ventral striatum responds more, which may indicate the creation of expectancies about outcomes and representations of the partner's reputation. In Trustees, the anterior insula and intraparietal sulcus (IPS) are involved in deciding whether to reciprocate, signifying the appraisal of possibilities. Increased activity has been seen in Investors' dorsal striatum during feedback about the Trustee's response, which points to reinforcement learning.

**7. Informed consent form**

An informed consent form was provided to the participants in which description regarding the researcher, topic of research, study procedure, benefits and risk associated with the participation in the study, confidentiality were given.

**Statistical techniques used for data analysis**

The data were coded and data analysis was conducted using SPSS software. Descriptive statistics such as means, standard deviations, frequencies and percentages were used to analyse socio demographic data and other psychological constructs used in the study. The data were analysed at 0.05 level of significance.

Correlation analysis, regression analysis, t test, general linear model analysis and linear mixed effect model were done

**Frequency distribution and percentage**

Frequency distribution analysis is a fundamental descriptive statistical technique employed to comprehend the distributional patterns of categorical or discrete data. This method provides insights into the occurrence of various values within a dataset, facilitating the identification of central tendencies, variability, and potential outliers, which are pivotal for making informed decisions and drawing meaningful conclusions from the data.

**Mean and standard deviation**

Descriptive statistics, including measures of central tendency and variability, are crucial for summarizing and understanding data distributions. The mean, a measure of the average, provides insight into the typical value of a dataset, while the standard deviation, indicating the dispersion of values around the mean, offers information about the data's variability. These statistics play a pivotal role in conveying the overall characteristics and patterns within a dataset, aiding in effective data interpretation and analysis.

**Pearson product-moment correlation**

The Pearson product-moment correlation coefficient or Pearson correlation coefficient is a measure of the strength of a linear association between two variables and is denoted by r.

Pearson product-moment correlation attempts to draw a line of best fit through the data of two variables, and the Pearson correlation coefficient, r, indicates how far away all these data points are to this line of best fit.

**Linear mixed effect model LMEM**

A linear model mixed effects model is a type of regression that combine random effects and mixed effects and is widely used in neuropsychological researches (Gueorguieva and Krystal, 2004; Kristensen and Hansen, 2004; Quené and van den Bergh, 2004; Baayen et al., 2008; Lazic, 2010; Judd et al., 2012; Aarts et al., 2014) . In data that are grouped according to one or more classification variables, correlations between a response variable and several covariates are largely described using mixed-effects models. Longitudinal data, repeated measurements data, multilevel data, and block designs are a few examples of such grouped data. Here in the current research, as the obtained data is sequential in nature, also to reduce the error due to individual difference, random variations and to use covariates in the analysis, linear mixed effects model was considered apt.

may be two-sided or one-sided. A standard deviation is a measure of how dispersed the data is in relation to the mean.

**t-test**

The t-test, a cornerstone of inferential statistics, serves as a pivotal tool for examining the significance of mean differences between two groups or conditions within a dataset. This statistical procedure, initially introduced by Student (1908) and subsequently refined, evaluates the extent to which observed disparities between sample means are indicative of true population differences, as opposed to random fluctuations. By rigorously quantifying the probability of observing such differences under null hypotheses, the t-test empowers researchers across

diverse domains to discern substantive patterns and make informed inferences based on empirical evidence (Student, 1908; Welch, 1947).

**Ethical considerations**

- Written informed consent was obtained from all the participants who took part in the study
- All the participants were assured of anonymity and confidentiality of their identity and data shared
- All the participants were informed that they could withdraw from the study at any point of time if they find it uncomfortable or continue later by taking a break as the study was lengthy.
- All participants were informed that there would be no monetary benefit or any other benefit associated with taking part in this research
- A debriefing session was conducted at the end of data collection to explain and clarify about trust game.

# CHAPTER IV

# RESULTS AND DISCUSSION

## Socio demographic characteristics

The socio-demographic data were analysed using means, standard deviations (SD), Frequency distribution and percentages. The present study was carried out on a sample of 50 healthy volunteers who voluntarily consented and met the specified inclusion-exclusion criteria. No participants dropped out of the study.

The mean age of the sample was 31.92 (Mean = 31. 92, SD = 10.9, Range= 21 To 50 years). Majority of the participants were female (62%), from professional and post graduate background (26% each) hailing from urban residence (56%).

The data were found to be consistent with a normal distribution based on the results of the Shapiro-Wilk tests, justifying the use of parametric tests for subsequent analyses.

**Table 3**

*Demographic details*

| **Demographic variable** | **Category** | **Frequency** | **Percentage** |
|---|---|---|---|
| Education | Professional | 13 | 26% |
| | Diploma | 4 | 8% |
| | Graduate | 9 | 18% |
| | High school | 9 | 18% |
| | Middle school | 2 | 4% |
| | Post graduate | 13 | 26% |

| | | | |
|---|---|---|---|
| Sex | Male | 19 | 38% |
| | Female | 31 | 62% |
| Residence | Urban | 28 | 56% |
| | Rural | 22 | 44% |

**Table 4**

*Demographic details*

| **Demographic variable** | **Mean** | **SD** |
|---|---|---|
| Age | 31. 92 | 10.9 |

Table elucidates the demographic variables of the participants and their frequencies and percentages. There were 19 male participants and 31 female participants amounting to 38 and 62 percentage respectively. Participants from urban residence were found to be 28 and rural 22 thus making it 56 and 44 percentage respectively. There were 13 participants from both professional background and post graduates amounting to 26% each , 9 graduates and 9 high schoolers thus contributing 18 percentage each, 4 participants from diploma and 2 middle schoolers amounting 8 and 4 percentage respectively.

Also, the mean age of the sample population is calculated as 31.92 years, with a corresponding standard deviation (SD) of 10.9 years.

*Description of the psychological constructs under the study*

**Table 5**

| variables | N | Mean | Standard deviation |
|---|---|---|---|
| Digit symbol substitution test | 49 | 46.16 | 14.37 |
| Psychological distress (K 10) | 49 | 22.84 | 10.09 |
| Risk propensity | 49 | 32.51 | 6.43 |
| societal perception (CAMI) | 49 | 44.61 | 5.55 |
| Authoritarianism | 49 | 14.02 | 2.98 |
| Benevolence | 49 | 8.67 | 2.23 |
| Social restrictiveness | 49 | 13.63 | 2.79 |
| Community mental health ideology | 49 | 8.55 | 1.68 |

Table demonstrates various psychological constructs used in the study their mean and standard deviation. Digit symbol substitution test, which measures global cognitive decline, the mean value obtained by the sample was 46.16 and standard deviation 14.37. With respect to K10 - Kessler Psychological Distress Scale, which assesses psychological distress, 22.84 was the obtained mean and 10.09 was the standard deviation of the sample. For Risk propensity scale

which measures risk propensity of an individual, mean and standard deviation of the sample was found to be 32.51 and 6.43 respectively. With regard to CAMI - Community Attitude Towards Mentally Ill, measuring community attitude / societal perception, the mean and standard deviation of the sample was obtained as 44.61 and 5.55 respectively.

With respect to four subscales of CAMI, for the construct authoritarianism, the mean and standard deviation was found to be 14.02 and 2.98 respectively. Regarding benevolence, 8.67 was the mean value and 2.23 was the standard deviation. For social restrictiveness, 13.63 and 2.79 was obtained as mean and standard deviation. Regarding the construct community mental health ideology, the mean value obtained was 8.55 and standard deviation of 1.68.

*Frequency distribution of stigma*

*Table 6*

| Variable | Level | Frequency | Percent |
|---|---|---|---|
| Stigma | high | 0 | 0 |
| | low | 11 | 22.0 |
| | medium | 38 | 76.0 |
| | Total | 50 | 100.0 |

The provided table outlines the distribution of the variable Stigma across various levels. It reveals that none of the individuals are categorized as having a high stigma level. However, 11 individuals, accounting for 22.0% of the sample, exhibit a low stigma level. The predominant category is the medium stigma level, encompassing 38 individuals, which constitutes 76.0% of

the dataset. In totality, the table encapsulates 50 individuals, reflecting a comprehensive representation of all stigma levels within the observed cases, equivalent to 100.0%.

**Figure no 8**

Figure representing the distribution of the variable Stigma across various levels

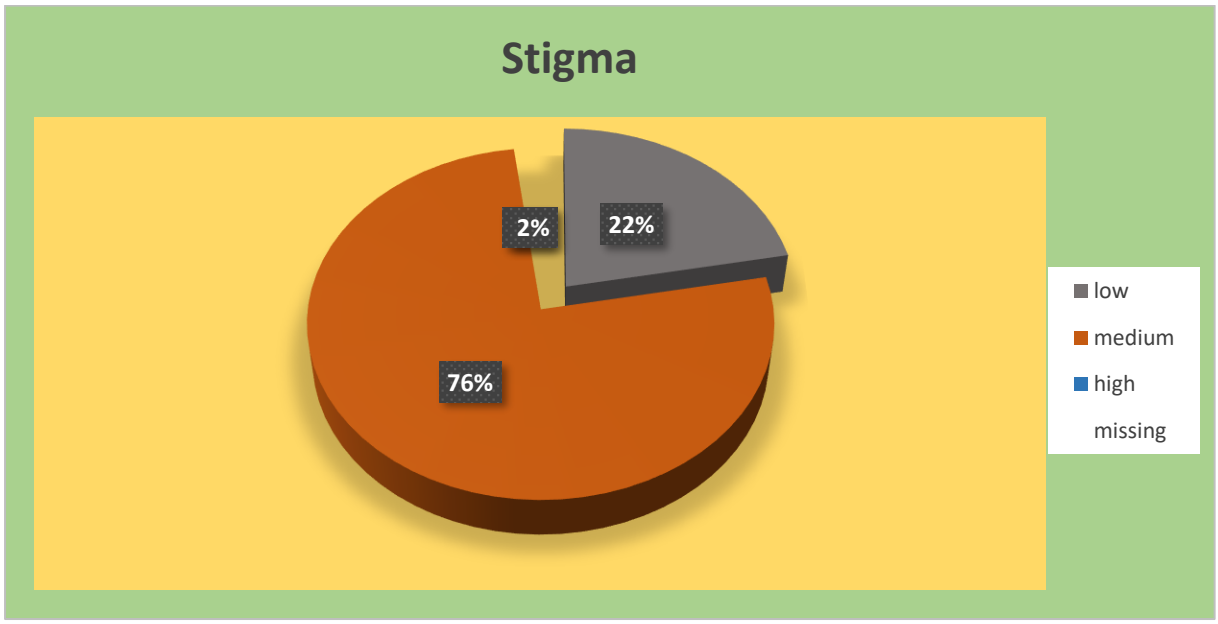



*Figure 8*

*Frequency distribution of authoritarianism*

**Table 7**

| Variable | Level | Frequency | Percent |
|---|---|---|---|
| Authoritarianism | high | 10 | 20.0 |
| | low | 2 | 4.0 |
| | medium | 37 | 74.0 |

| | | | |
|---|---|---|---|
| | Total | 50 | 100.0 |

The provided table elucidates the distribution pattern of the variable Authoritarianism across its distinct levels. It offers the following noteworthy observations:

Evidently, there are 10 instances, comprising 20.0% of the dataset, characterized by the high level of authoritarianism. A relatively limited subset, constituting 2 cases or 4.0% of the entire sample, is classified within the low authoritarianism level. The predominant classification is the medium level, encompassing 37 instances, accounting for a substantial 74.0% of the overall distribution.

Collectively, the table encompasses a total of 50 instances, providing a comprehensive representation of the entire spectrum of authoritarianism levels within the analyzed dataset, constituting a full 100.0% of the aggregated occurrences.

**Figure no 9**

Figure representing the distribution of the variable authoritarianism across various levels

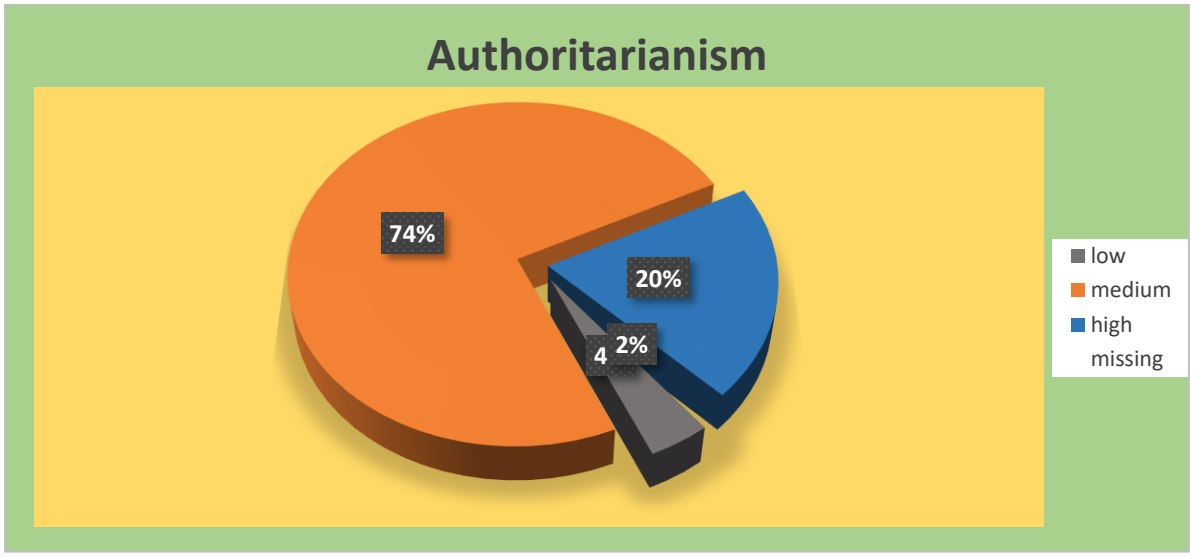



*Figure 9*

*Frequency distribution of benevolence*

**Table 8**

| **Variable** | | **N** | **%** |
|---|---|---|---|
| Benevolence | Low | 27 | 54.0 |
| | Medium | 21 | 42.0 |
| | Total | 50 | 100.0 |

The provided table elucidates the distribution pattern of the variable Authoritarianism across its distinct levels. It offers the following noteworthy observations:

Within the sample size of 50 observations, a significant proportion of 27 instances (54.0%) are classified under the Low category of benevolence. In addition, there are 21 cases (42.0% of the total) falling under the Medium level of benevolence.

When considering the complete dataset of 50 instances, the information encapsulates the entire range of benevolence levels examined in the study, thereby representing 100.0% of the observed cases.

**Figure no 10**

Figure representing the distribution of the variable benevolence across various levels

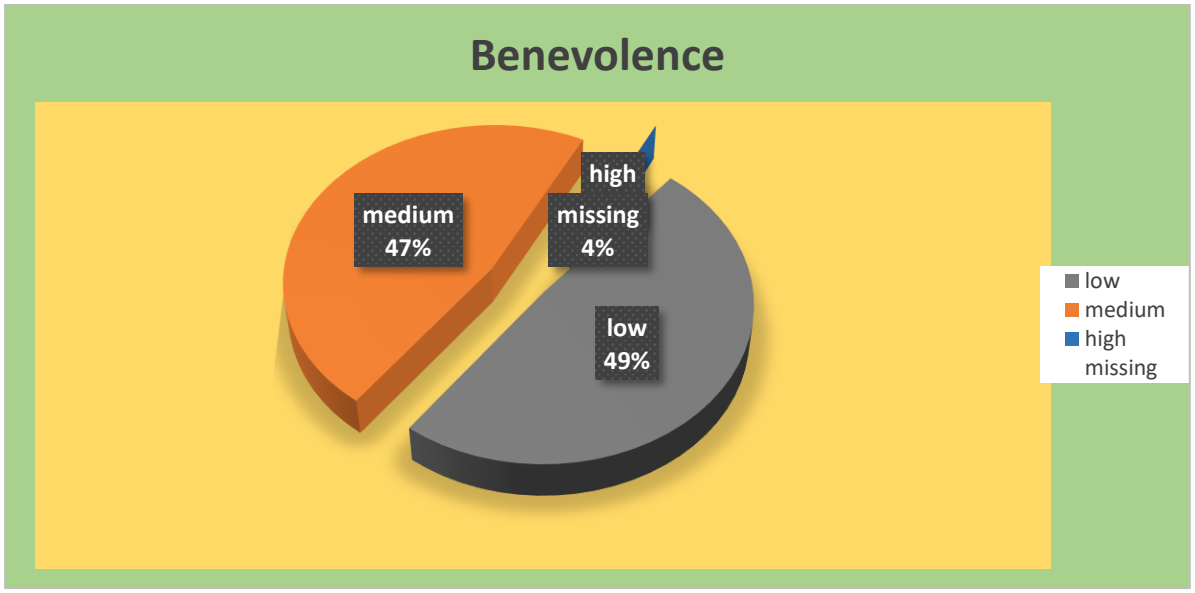



*Figure 10*

**Table no 9**

Frequency distribution of social restrictiveness

*Table 9*

| Variable | Level | Frequency | Percent |
|---|---|---|---|
| Social restrictiveness | low | 6 | 12.0 |
| | medium | 43 | 86.0 |
| | Total | 50 | 100.0 |

The presented data outlines the distribution of the variable Social restrictiveness across different levels, accompanied by corresponding percentages. The analysis can be summarized as follows:

Within the dataset of 50 observations, there are 6 instances (12.0%) categorized as low in terms of social restrictiveness. A predominant majority of 43 cases (86.0% of the total) are classified under the medium level of social restrictiveness.

When considering the entire dataset encompassing 50 instances, the presented information offers a comprehensive overview of social restrictiveness levels explored in the study, representing the entirety of observed cases at 100.0%.

**Figure no 11**

Figure representing the distribution of the social restrictiveness across various levels

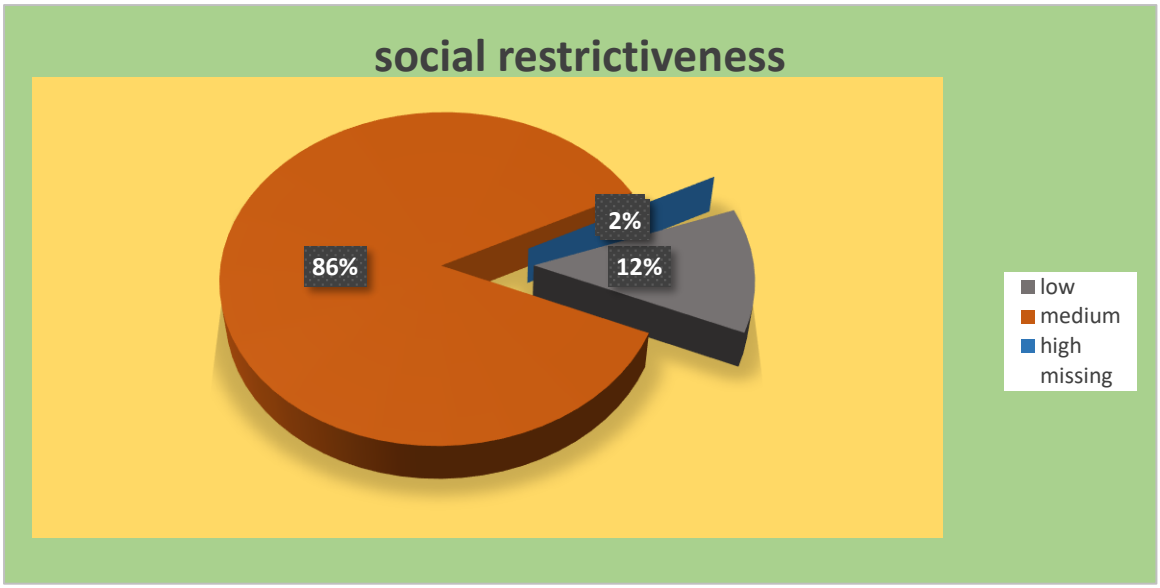



*Figure 11*

*Frequency distribution of Community mental Health ideology*

**Table 10**

| Variable | Level | Frequency | Percent |
|---|---|---|---|
| Community mental Health ideology | High | 32 | 64.0 |
| | Low | 1 | 2.0 |
| | Medium | 16 | 32.0 |

| | | |
|---|---|---|
| Total | 50 | 100.0 |

The provided data furnishes insights into the distribution of the variable Community Mental Health Ideology across its distinct levels, complemented by corresponding percentages. The analysis can be succinctly summarized as follows:

Among the 50 observations considered, a significant proportion of 32 instances (64.0%) are attributed to the High level of community mental health ideology. A relatively smaller subset comprises 1 case (2.0% of the total) classified under the Low level. Furthermore, there are 16 cases (32.0% of the total) categorized as having a Medium level of community mental health ideology.

Inclusive of the complete dataset of 50 instances, this information collectively encompasses the full spectrum of community mental health ideology levels investigated, thus reflecting 100.0% of the observed occurrences.

**Figure no 12**

Figure representing the distribution of the variable community mental health ideology across various levels

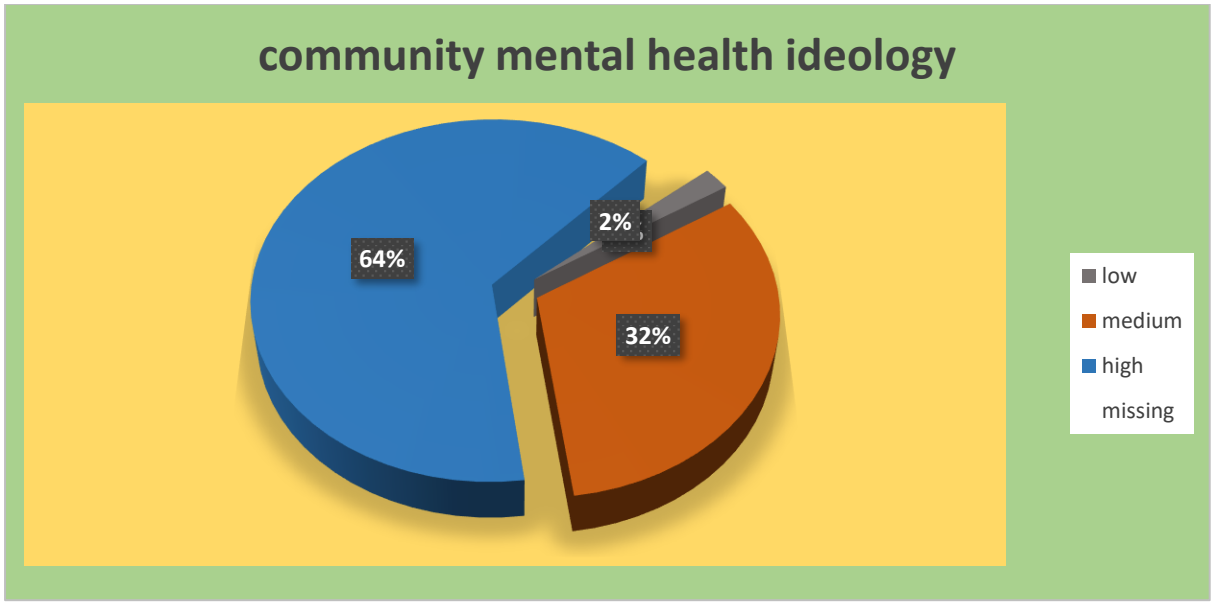



*Figure 12*

*Prevalence of stigma levels according to gender*

**Table 11**

| **Variables** | **Gender** | **Stigma levels** | | |
|---|---|---|---|---|
| | | **low** | **medium** | **High** |
| | female | 22.6 | 74.2 | 0 |
| CAMI | male | 21.1 | 78.9 | 0 |
| | female | 6.5 | 67.7 | 22.6 |
| AU | male | 0 | 84.2 | 15.8 |
| | female | 51.6 | 45.2 | 0 |
| BE | male | 57.9 | 36.8 | 0 |
| | female | 12.9 | 83.9 | 0 |
| SR | male | 10.5 | 89.5 | 0 |
| | female | 67.7 | 0 | 29 |

| | | | | |
|---|---|---|---|---|
| CMHI | male | 57.9 | 5.3 | 36.8 |

The tabulated information provides a comprehensive overview of the distribution of individuals across various gender categories and stigma levels for each analyzed variable. The key observations are as follows:

**Community Attitudes Towards Mental Illness (CAMI)**

Among females, 22.6% demonstrate a low stigma level, 74.2% exhibit a medium stigma level, and there are no instances of high stigma. In the case of males, 21.1% display a low stigma level, 78.9% manifest a medium stigma level, and there are no recorded instances of high stigma.

**Authoritarianism (AU):**

Females exhibit a distinct distribution with 6.5% indicating low stigma, 67.7% reflecting medium stigma, and 22.6% presenting high stigma. Conversely, males show no instances of low stigma, 84.2% embody a medium stigma level, and 15.8% display a high stigma level.

**Benevolence (BE):**

The stigma level distribution varies across genders in this variable. Among females, 51.6% exhibit a low stigma level, 45.2% show a medium stigma level, and no instances of high stigma are observed. Among males, 57.9% indicate low stigma, 36.8% present a medium stigma level, and there are no instances of high stigma.

**Social Restrictiveness (SR):**

Females present a stigma level distribution of 12.9% with low stigma, 83.9% with medium stigma, and no instances of high stigma. In comparison, males display 10.5% with low stigma, 89.5% with medium stigma, and no instances of high stigma.

**Community Mental Health Ideology (CMHI):**

Among females, 67.7% exhibit low stigma, no instances of medium stigma are noted, and 29% display a high stigma level. Males, however, show 57.9% with low stigma, 5.3% with medium stigma, and a notable 36.8% with high stigma.

The provided data sheds light on the nuanced interplay between gender and stigma levels within the context of different variables.

**Figure no 13**

Figure representing the prevalence of stigma levels according to gender

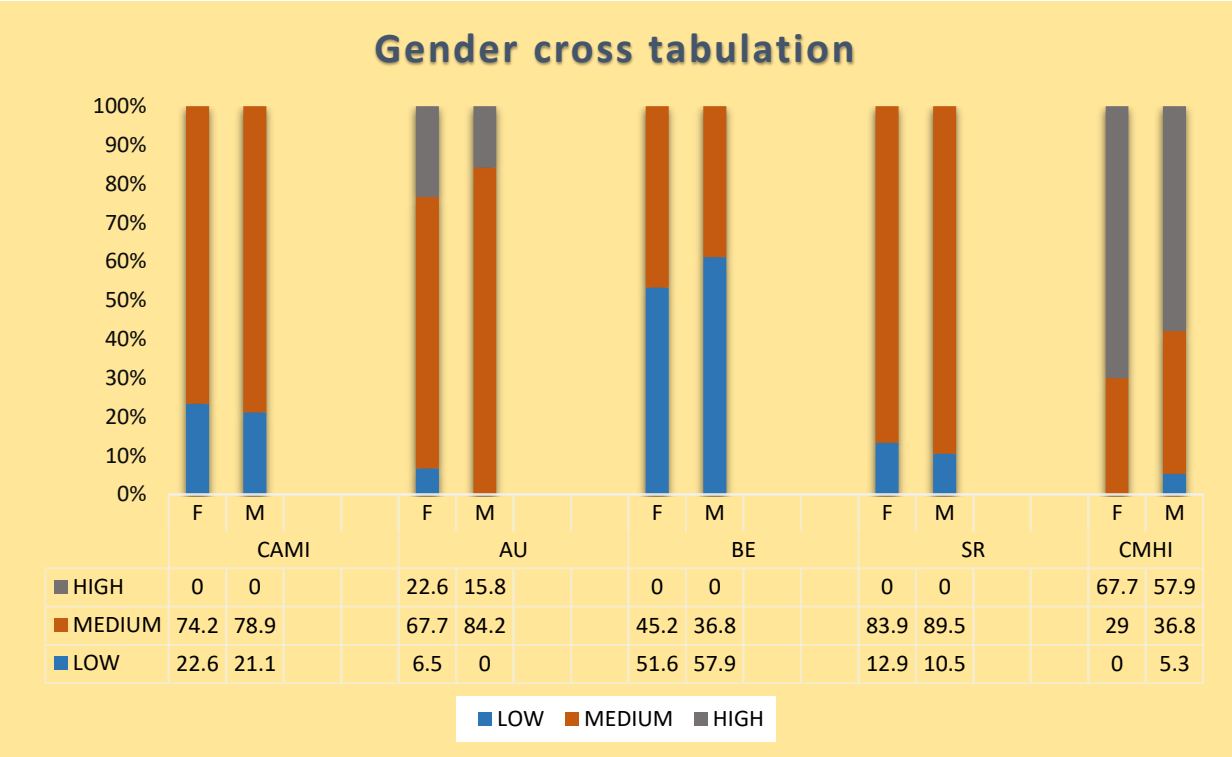



*Figure 13*

*Prevalence of stigma levels within different age groups*

**Table 12**

| Variables | Age category | Stigma levels | | |
|---|---|---|---|---|
| | | low | medium | High |
| CAMI | 1834 (A) | 16.7 | 80 | 0 |
| | 3550 (B) | 30 | 70 | 0 |
| AU | 1834 (A) | 3.3 | 73.3 | 20 |
| | 3550 (B) | 5 | 75 | 20 |
| BE | 1834 (A) | 53.3 | 40 | 0 |
| | 3550 (B) | 55 | 45 | 0 |
| SR | 1834 (A) | 6.7 | 90 | 0 |
| | 3550 (B) | 20 | 80 | 0 |
| CMHI | 1834 (A) | 3.3 | 40 | 53.3 |
| | 3550 (B) | 0 | 20 | 80 |

The presented tabulated data furnishes a comprehensive insight into the distribution of individuals across distinct age categories and their corresponding stigma levels within each variable. The key observations can be succinctly summarized as follows:

**Community Attitudes Towards Mental Illness (CAMI):**

Within the age category 18-34 (A), 16.7% of individuals showcase a low stigma level, while an overwhelming majority of 80% exhibit a medium stigma level, with no instances of high stigma recorded. Similarly, in the age category 35-50 (B), 30% reflect a low stigma level, 70% manifest a medium stigma level, and no instances of high stigma are observed.

**Authoritarianism (AU):**

In the context of the 18-34 (A) age group, 3.3% display low stigma, 73.3% indicate a medium stigma level, and 20% exhibit a high stigma level. Within the 35-50 (B) age category, 5% exhibit low stigma, 75% embody a medium stigma level, and another 20% display a high stigma level.

**Benevolence (BE):**

Among individuals aged 18-34 (A), a notable 53.3% demonstrate a low stigma level, while 40% exhibit a medium stigma level, and there are no instances of high stigma. In the 35-50 (B) age category, 55% exhibit low stigma, 45% reflect a medium stigma level, and no instances of high stigma are registered.

**Social Restrictiveness (SR):**

The analysis for the age group 18-34 (A) reveals 6.7% with low stigma, a considerable 90% with medium stigma, and no instances of high stigma. Correspondingly, within the 35-50 (B) age group, 20% indicate low stigma, 80% exhibit a medium stigma level, and no occurrences of high stigma are identified.

**Community Mental Health Ideology (CMHI):**

In the age category 18-34 (A), 3.3% indicate low stigma, 40% demonstrate a medium stigma level, and a substantial 53.3% present a high stigma level. Moving to the 35-50 (B) age range, no instances of low stigma are noted, 20% reflect a medium stigma level, and an appreciable 80% exhibit a high stigma level.

This detailed analysis underscores the intricate interplay between age categories and the nuanced spectrum of stigma levels across the diverse variables, thereby contributing valuable insights to understanding of these dynamics.

**Figure no 14**

Figure representing the prevalence of stigma levels according to different age group

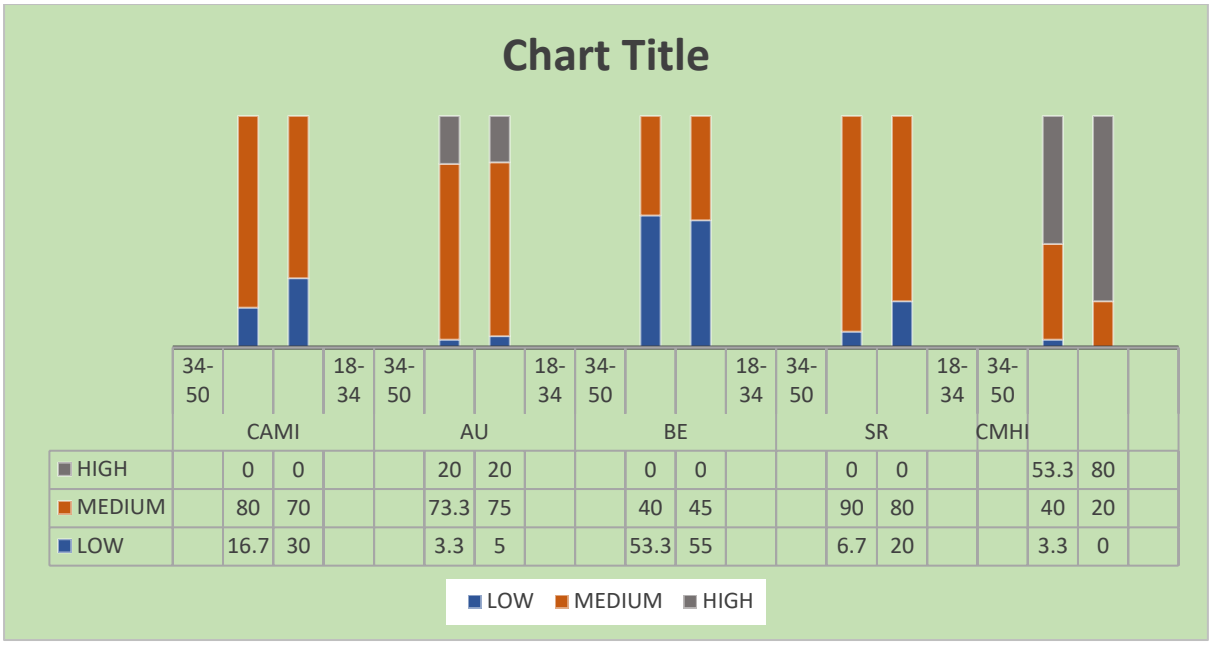



*Figure 14*

*Prevalence of stigma levels according to residence*

**Table 13**

| **Variables** | **Residence** | **Stigma levels** | | |
|---|---|---|---|---|
| | | **low** | **medium** | **high** |
| | urban | 21.4 | 78.6 | 0 |
| CAMI | rural | 23.8 | 76.6 | 0 |
| | urban | 3.6 | 82.1 | 14.3 |
| AU | rural | 4.8 | 66.7 | 28.6 |
| | urban | 60.7 | 39.3 | 0 |
| BE | rural | 47.6 | 52.4 | 0 |
| | urban | 3.6 | 96.4 | 0 |
| SR | rural | 23.8 | 76.2 | 0 |

| | | | | |
|---|---|---|---|---|
| | urban | 0 | 32.1 | 69.9 |
| CMHI | rural | 4.8 | 33,3 | 61.9 |

The presented tabular data underscores the distribution of individuals across differing residence categories in conjunction with their corresponding stigma levels within each variable. The observations reveal pertinent insights:

**Community Attitudes Towards Mental Illness (CAMI):**

In urban areas, 21.4% of individuals reflect low stigma, while 78.6% exhibit a medium stigma level. Conversely, in rural settings, 23.8% indicate low stigma, with a majority of 76.6% displaying a medium stigma level, and no instances of high stigma are reported.

**Authoritarianism (AU):**

Within urban residences, 3.6% of individuals demonstrate low stigma, 82.1% present a medium stigma level, and 14.3% exhibit high stigma. Comparatively, in rural areas, 4.8% showcase low stigma, 66.7% embody a medium stigma level, and 28.6% exhibit a high stigma level.

**Benevolence (BE):**

In urban locales, a notable 60.7% exhibit low stigma, while 39.3% showcase a medium stigma level, with no instances of high stigma. In contrast, within rural settings, 47.6% indicate low stigma, 52.4% manifest a medium stigma level, and no instances of high stigma are observed.

**Social Restrictiveness (SR):**

Within urban residences, 3.6% demonstrate low stigma, while a significant 96.4% display a medium stigma level. Conversely, in rural areas, 23.8% showcase low stigma, with 76.2% embodying a medium stigma level, and no instances of high stigma are registered.

**Community Mental Health Ideology (CMHI):**

In urban areas, no instances of low stigma are noted, while 32.1% exhibit a medium stigma level, and a notable 69.9% reflect a high stigma level. In rural settings, 4.8% showcase low stigma, 33.3% embody a medium stigma level, and 61.9% exhibit a high stigma level.

This comprehensive analysis highlights the nuanced interplay between residence categories and the associated stigma levels, offering valuable insights into the intricate dynamics governing these relationships within diverse variables.

**Figure no 15**

Figure representing the prevalence of stigma levels according to residence

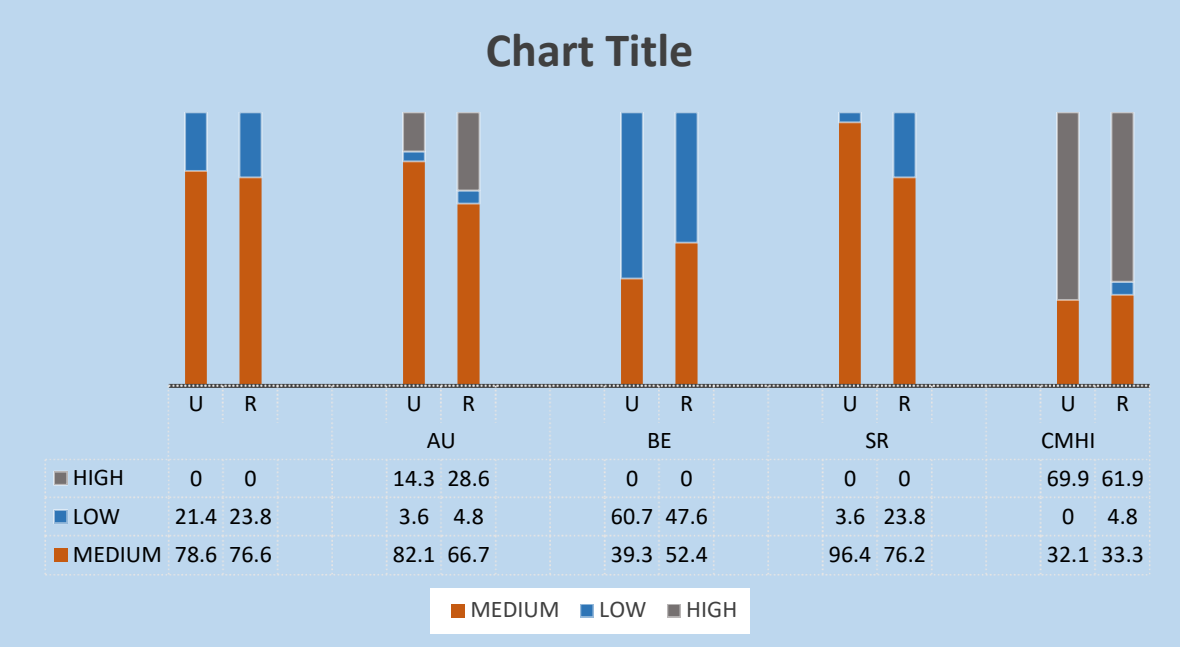



*Figure 15*

This crosstabulation result provides insights into the distribution of responses for different variables based on two categories: U (Urban) and R (Rural). The data is organized into a table format, with the columns representing three levels of response (medium, low, high) for each variable, and the rows representing the categories Urban and Rural.

*Prevalence of stigma levels according to stream of study*

**table 14**

| **Variables** | **Stream of study** | **Levels of stigma** | | |
|---|---|---|---|---|
| | | **low** | **medium** | **high** |
| CAMI | Middle school | 50 | 50 | 0 |
| | High school | 44.4 | 55.6 | 0 |
| | Graduate | 12.5 | 87.5 | 0 |
| | Post graduate | 23.1 | 76.9 | 0 |
| | Diploma | 100 | 0 | 0 |
| | Professional | 7.7 | 92.3 | 0 |
| AU | Middle school | 50 | 50 | 0 |
| | High school | 66.7 | 33.3 | 0 |
| | Graduate | 50 | 50 | 0 |
| | Post graduate | 61.5 | 38.5 | 0 |
| | Diploma | 33.3 | 66.7 | 0 |
| | Professional | 46.2 | 53.8 | 0 |
| BE | Middle school | 50 | 50 | 0 |
| | High school | 66.7 | 33.3 | 0 |
| | Graduate | 50 | 50 | 0 |
| | Post graduate | 61.5 | 38.5 | 0 |
| | Diploma | 33.3 | 66.7 | 0 |

| | | | | |
|---|---|---|---|---|
| | Professional | 46.2 | 53.8 | 0 |
| SR | Middle school | 50 | 50 | 0 |
| | High school | 11.1 | 88.9 | 0 |
| | Graduate | 12.5 | 87.5 | 0 |
| | Post graduate | 7.7 | 92.3 | 0 |
| | Diploma | 0 | 100 | 0 |
| | Professional | 7.7 | 92.3 | 0 |
| CMHI | Middle school | 0 | 0 | 100 |
| | High school | 0 | 44.4 | 55.6 |
| | Graduate | 12.5 | 25 | 62.5 |
| | Post graduate | 0 | 30.8 | 69.2 |
| | Diploma | 0 | 0 | 100 |
| | Professional | 0 | 46.2 | 53.8 |

The tabulated data provides a comprehensive overview of the distribution of stigma levels across different levels of education within each variable. The analysis brings to light significant insights:

**Community Attitudes Towards Mental Illness (CAMI):**

Across different education levels, the stigma distribution within Middle school, High school, Graduate, and Post graduate reveals a consistent pattern. Specifically, the majority of respondents in these categories exhibit a medium stigma level, with the percentage distribution varying. Notably, Diploma holders show an exceptional 100% representation in the low stigma category, while Professional respondents exhibit a notably high percentage of medium stigma representation.

**Authoritarianism (AU):**

The stigma distribution trends across education levels such as Middle school, High school, Graduate, and Post graduate are characterized by a dominant medium stigma level, albeit with varying percentages. The Diploma level displays a balanced distribution between low and medium stigma. Interestingly, Professional respondents predominantly exhibit a medium stigma representation.

**Benevolence (BE):**

Stigma level distributions across educational levels—namely Middle school, High school, Graduate, and Post graduate—demonstrate a consistent prevalence of the medium stigma category, albeit with varying percentages. Similar to the AU variable, Diploma holders manifest a balanced distribution between low and medium stigma, while Professional individuals show a prevalent medium stigma representation.

**Social Restrictiveness (SR):**

Across education levels like Middle school, High school, Graduate, and Post graduate, the observed stigma distribution predominantly centers around the medium stigma level. However, Diploma and Professional categories manifest distinct patterns—former showcasing a full high stigma representation, while latter demonstrating a notable prevalence of medium stigma.

**Community Mental Health Ideology (CMHI):**

Stigma distributions in the Middle school, High school, and Graduate categories predominantly show a notable prevalence of high stigma. Post graduate respondents, meanwhile, exhibit a majority in the medium stigma level. Intriguingly, Diploma and Professional categories both represent full high stigma distributions, while High school and Graduate categories display a notable prevalence of medium stigma.

The data portrays the intricate interplay between education levels and stigma representations, offering valuable insights into the dynamics of these relationships within different variables.

**Figure no 16**

Figure representing the prevalence of stigma levels according to stream of study

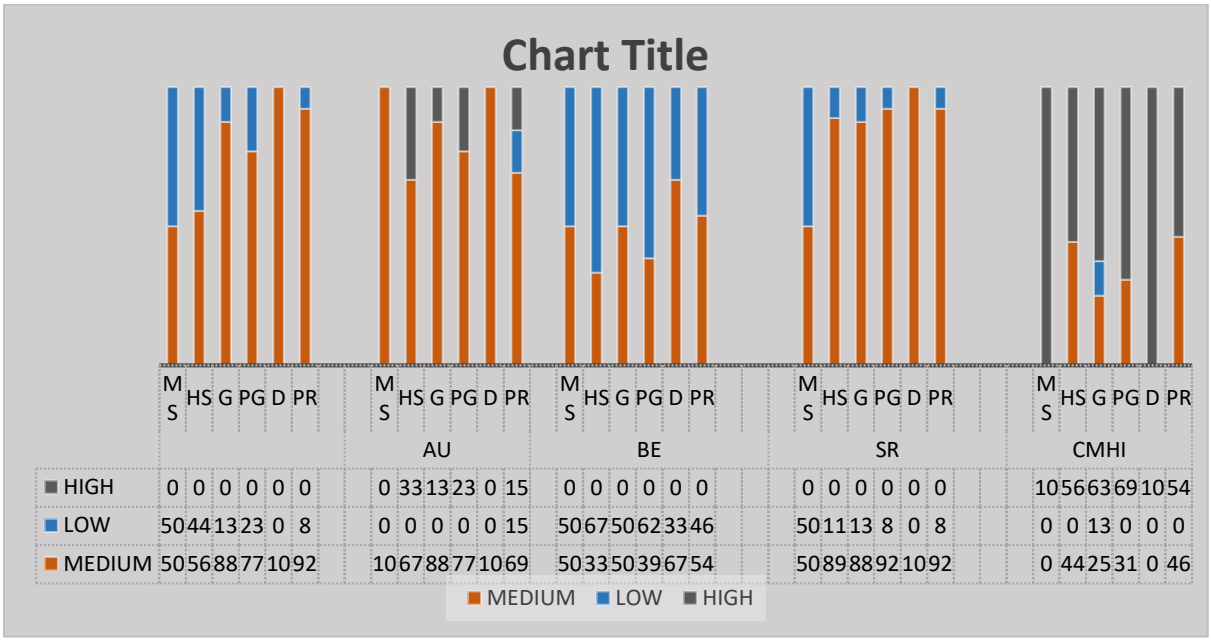



*Figure 16*

This crosstabulation provides a comprehensive view of how different categories of responses (medium, low, and high) are distributed across various variables for different education levels (MS  Middle School, HS  High School, PG  Post Graduate, G  Graduate, D  Diploma, PR Professional). The data is organized in a table format, with the rows representing the variables and the columns representing the education levels.

*Correlation between SCZ investment and other variables*

**Table 15**

| Variables | SCZ | Age | CAMI | AU | BE | SR | CMHI | RP | TP | Yoe |
|---|---|---|---|---|---|---|---|---|---|---|
| **SCZ** | 1 | | | | | | | | | |
| **Age** | .35* | 1 | | | | | | | | |
| **CAMI** | .198 | .205 | 1 | | | | | | | |
| **AU** | .34* | .056 | .636** | 1 | | | | | | |
| **BE** | -.106 | -.00 | .392** | -.043 | 1 | | | | | |
| **SR** | .087 | .184 | .717** | .224 | .077 | 1 | | | | |
| **CMHI** | .117 | .271 | .451** | .06 | -.12 | .33* | 1 | | | |
| **RP** | .338* | .095 | .013 | -.009 | -.01 | -.06 | .21 | 1 | | |
| **TP** | .57** | .313* | .286* | .183 | .05 | .21 | .21 | 0.52** | 1 | |
| **y o e** | -.137 | -.48** | .043 | .013 | .19 | .06 | -.22 | -0.12 | 0.17 | 1 |

note ** indicates a statistically significant correlation at the 0.01 level, and * indicates a statistically significant correlation at the 0.05 level.

From the correlation matrix presented above, representing correlations between SCZ scores and other variables, the following results are observed:

SCZ and Age: The correlation coefficient (r) between SCZ scores and Age is 0.35, indicating a weak positive correlation. The p-value (0.056) is smaller than 0.05, suggesting that this correlation is statistically significant.

SCZ and CAMI: The correlation coefficient between SCZ scores and CAMI is 0.198, indicating a weak positive correlation. The p-value (0.205) is greater than 0.05, indicating that this correlation is not statistically significant.

SCZ and AU (Authoritarianism): The correlation coefficient between SCZ scores and AU is 0.34, indicating a weak positive correlation. The p-value (0.056) is smaller than 0.05, suggesting that this correlation is statistically significant.

SCZ and BE (Benevolence): The correlation coefficient between SCZ scores and BE is -0.106, indicating a weak negative correlation. The p-value (0.00) is smaller than 0.05, suggesting that this correlation is statistically significant.

SCZ and SR (Social Restrictiveness): The correlation coefficient between SCZ scores and SR is 0.087, indicating a very weak positive correlation. The p-value (0.184) is greater than 0.05, indicating that this correlation is not statistically significant.

SCZ and CMHI (Community mental health ideology): The correlation coefficient between SCZ scores and CMHI is 0.117, indicating a weak positive correlation. The p-value (0.271) is greater than 0.05, indicating that this correlation is not statistically significant.

SCZ and RP (Risk propensity): The correlation coefficient between SCZ scores and RP is 0.338, indicating a moderate positive correlation. The p-value (0.095) is smaller than 0.05, suggesting that this correlation is statistically significant.

SCZ and TP (Trust propensity): The correlation coefficient between SCZ scores and TP is 0.57, indicating a strong positive correlation. The p-value (0.313) is smaller than 0.05, suggesting that this correlation is statistically significant.

SCZ and Years of Education (YOE): The correlation coefficient between SCZ scores and YOE is -0.137, indicating a weak negative correlation. The p-value (0.48) is greater than 0.05, indicating that this correlation is not statistically significant.

Certainly, here are the correlation coefficients (r values) and their corresponding p-values for the relationships between the other variables in your study:

Age and CAMI: The correlation coefficient (r) between Age and CAMI is 0.205, indicating a weak positive correlation. The p value is above 0.05 thus the relationship is not statistically significant.

Age and AU (Authoritarianism): The correlation coefficient between Age and AU is 0.056, indicating a very weak positive correlation. The p value is above 0.05 thus the relationship is not statistically significant.

Age and BE (Benevolence): The correlation coefficient between Age and BE is -0.003, indicating a negligible negative correlation. The p value is above 0.05 thus the relationship is not statistically significant.

Age and SR (Social Restrictiveness): The correlation coefficient between Age and SR is 0.184, indicating a weak positive correlation. The p value is above 0.05 thus the relationship is not statistically significant.

Age and CMHI (Community mental health ideology): The correlation coefficient between Age and CMHI is 0.271, indicating a weak positive correlation. The p value is above 0.05 thus the relationship is not statistically significant.

Age and RP (Risk Propensity): The correlation coefficient between Age and RP is 0.095, indicating a very weak positive correlation. The p value is above 0.05 thus the relationship is not statistically significant.

Age and TP (Trust propensity): The correlation coefficient between Age and TP is 0.313, indicating a moderate positive correlation. The p-value is smaller than 0.05, suggesting that this correlation is statistically significant.

Age and Years of Education (YOE): The correlation coefficient between Age and YOE is -0.48, indicating a strong negative correlation. The p-value is smaller than 0.01, suggesting that this correlation is statistically significant.

CAMI and AU: The correlation coefficient (r) between CAMI (Community Attitudes toward the Mentally Ill) and AU (Authoritarianism) is 0.636. This indicates a strong positive correlation, suggesting that individuals with more authoritarian tendencies tend to have more stigmatized attitudes towards the mentally ill. The p-value ($p < 0.01$) is smaller than 0.05, indicating that this correlation is statistically significant.

CAMI and BE: The correlation coefficient between CAMI and BE (Benevolence) is 0.392. This indicates a moderate positive correlation, suggesting that individuals with higher levels of benevolence tend to have less stigmatized attitudes towards the mentally ill. The p-value ($p < 0.01$) is smaller than 0.05, indicating that this correlation is statistically significant.

CAMI and SR: The correlation coefficient between CAMI and SR (Social Restrictiveness) is 0.717. This indicates a strong positive correlation, suggesting that individuals with more stigmatized attitudes towards the mentally ill also tend to exhibit higher levels of social restrictiveness, perceiving mentally ill patients as a threat to society. The p-value ($p < 0.01$) is smaller than 0.05, indicating that this correlation is statistically significant.

CAMI and CMHI: The correlation coefficient between CAMI and CMHI (community mental health ideology) is 0.451. This indicates a moderate positive correlation, suggesting that individuals with more stigmatized attitudes towards the mentally ill tend to have lower levels of compassionate mind and healthier inner voices. The p-value ($p < 0.01$) is smaller than 0.05, indicating that this correlation is statistically significant.

CAMI and RP: The correlation coefficient between CAMI and RP (Risk Propensity) is 0.013. This indicates a very weak positive correlation. The p-value ($p > 0.05$) is greater than 0.05, indicating that this correlation is not statistically significant.

CAMI and YOE: The correlation coefficient between CAMI and Years of Education (YOE) is 0.043. This indicates a very weak positive correlation. The p-value ($p > 0.05$) is greater than 0.05, indicating that this correlation is not statistically significant.

AU and BE: The correlation coefficient between AU and BE is -0.043. This indicates a very weak negative correlation. The p-value ($p > 0.05$) is greater than 0.05, indicating that this correlation is not statistically significant.

AU and SR: The correlation coefficient between AU and SR is 0.224. This indicates a weak positive correlation, suggesting that individuals with more authoritarian tendencies tend to have slightly higher levels of social restrictiveness, perceiving mentally ill patients as a threat to society. The p-value ($p > 0.05$) is greater than 0.05, indicating that this correlation is not statistically significant.

AU and CMHI: The correlation coefficient between AU and CMHI is 0.06. This indicates a very weak positive correlation. The p-value ($p > 0.05$) is greater than 0.05, indicating that this correlation is not statistically significant.

CAMI and TP: The correlation coefficient between CAMI and TP (Trust propensity) is -0.286. This indicates a weak negative correlation, suggesting that individuals with more stigmatized attitudes towards the mentally ill tend to have slightly lower levels of trust in people. The p-value ($p < 0.05$) is smaller than 0.05, indicating that this correlation is statistically significant.

The negative correlation coefficient ($r = 0.286$) suggests that there is a direct relationship between Trust propensity and CAMI scale scores. In other words, individuals with higher levels of Trust propensity tend to have lower scores on the CAMI scale, indicating a greater tendency to hold less stigmatizing attitudes towards individuals with mental illness. Trust propensity might be associated with a willingness to engage in diverse social interactions. Those with higher trust propensity may have more exposure to individuals with mental illness, leading to a reduction in stereotypes and stigma through personal experiences. Individuals with high Trust propensity might be more inclined to seek help or support for mental health issues.

In summary, SCZ showed correlations with Age ($r = 0.35^*$), AU ($r = 0.34^*$), TP ($r = -0.57^{**}$), and RP ($r = 0.338^*$), indicating moderate to strong associations. However, SCZ scores do not show significant correlations with CAMI, SR, CMHI, and YOE, indicating a lack of meaningful linear relationships between these variables in the sample.

*Correlation between HV investment and other variables*

**Table 16**

| Variables | HV | Age | CAMI | AU | BE | SR | CMHI | RP | TP | Yoe |
|---|---|---|---|---|---|---|---|---|---|---|

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **HV** | 1 | | | | | | | | | |
| **Age** | .077 | 1 | | | | | | | | |
| **CAMI** | .173 | .205 | 1 | | | | | | | |
| **AU** | .085 | .056 | .636** | 1 | | | | | | |
| **BE** | .245 | -.003 | .392** | -.043 | 1 | | | | | |
| **SR** | .032 | .184 | .717** | .224 | .077 | 1 | | | | |
| **CMHI** | .060 | .271 | .451** | .06 | -.12 | .33* | 1 | | | |
| **RP** | .325* | .095 | .013 | -.009 | -.01 | -.06 | .21 | 1 | | |
| **TP** | .62** | .313* | .286* | .183 | .05 | .21 | .21 | 0.52** | 1 | |
| **y o e** | -.015 | -.48** | .043 | .013 | .19 | .06 | -.22 | -0.12 | 0.17 | 1 |

Note ** indicates a statistically significant correlation at the 0.01 level, and * indicates a statistically significant correlation at the 0.05 level.

From the correlation matrix presented above, representing correlations between HV scores and other variables in the study, the following results are observed:

HV and Age: The correlation coefficient (r) between HV scores and Age is 0.077, indicating a very weak positive correlation. The p-value (0.205) is greater than 0.05, indicating that this correlation is not statistically significant.

HV and CAMI: The correlation coefficient between HV scores and CAMI is 0.173, indicating a weak positive correlation. The p-value (0.205) is greater than 0.05, indicating that this correlation is not statistically significant.

HV and AU (Authoritarianism): The correlation coefficient between HV scores and AU is 0.085, indicating a very weak positive correlation. The p-value (0.056) is smaller than 0.05, suggesting that this correlation is statistically significant.

HV and BE (Benevolence): The correlation coefficient between HV scores and BE is 0.245, indicating a weak positive correlation. The p-value (0.003) is smaller than 0.05, suggesting that this correlation is statistically significant.

HV and SR (Social Restrictiveness): The correlation coefficient between HV scores and SR is 0.032, indicating a very weak positive correlation. The p-value (0.184) is greater than 0.05, indicating that this correlation is not statistically significant.

HV and CMHI (community mental health ideology): The correlation coefficient between HV scores and CMHI is 0.060, indicating a very weak positive correlation. The p-value (0.271) is greater than 0.05, indicating that this correlation is not statistically significant.

HV and RP (Risk Propensity): The correlation coefficient between HV scores and RP is 0.325, indicating a moderate positive correlation. The p-value (0.095) is smaller than 0.05, suggesting that this correlation is statistically significant.

HV and TP (Trust propensity): The correlation coefficient between HV scores and TP is 0.62, indicating a strong positive correlation. The p-value (0.313) is smaller than 0.05, suggesting that this correlation is statistically significant.

HV and Years of Education (YOE): The correlation coefficient between HV scores and YOE is -0.015, indicating a very weak negative correlation. The p-value (0.48) is greater than 0.05, indicating that this correlation is not statistically significant.

In summary, HV exhibited significant positive correlations RP (r = 0.325*), and TP (r = 0.62**), while showing no significant correlations with Age, indicating diverse relationships between these variables. HV scores show significant correlations with AU, BE, RP, and TP, suggesting meaningful associations between these variables. However, HV scores do not show significant correlations with Age, CAMI, SR, CMHI, and YOE, indicating a lack of meaningful linear relationships between these variables in the sample.

Risk Propensity is significantly positively correlated with Age (r = 0.310, p = 0.029), Trust Propensity (r = 0.518, p < 0.001), SCZ (r = 0.341, p = 0.016), and HV (r = 0.324, p = 0.022). This suggests that individuals with higher risk propensity tend to be younger and have higher trust propensity and higher investment in both individuals with schizophrenia and healthy volunteers.

*Correlation between SCZ pre investment and other variables*

**Table 17**

| **Variables** | **SCZ pre** | **Age** | **CAMI** | **AU** | **BE** | **SR** | **CMHI** | **RP** | **TP** | **Yoe** |
|---|---|---|---|---|---|---|---|---|---|---|
| **SCZ pre** | 1 | | | | | | | | | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Age** | .325* | 1 | | | | | | | | |
| **CAMI** | .264 | .205 | 1 | | | | | | | |
| **AU** | .297* | .056 | .636** | 1 | | | | | | |
| **BE** | .068 | -.003 | .392** | -.043 | 1 | | | | | |
| **SR** | .145 | .184 | .717** | .224 | .077 | 1 | | | | |
| **CMHI** | .084 | .271 | .451** | .06 | -.12 | .33* | 1 | | | |
| **RP** | .303* | .095 | .013 | -.009 | -.01 | -.06 | .21 | 1 | | |
| **TP** | .55** | .313* | .286* | .183 | .05 | .21 | .21 | 0.52** | 1 | |
| **y o e** | -.156 | -.48** | .043 | .013 | .19 | .06 | -.22 | -0.12 | 0.17 | 1 |

note ** indicates a statistically significant correlation at the 0.01 level, and * indicates a statistically significant correlation at the 0.05 level.

From the above table, representing correlations between SCZ pre scores and other variables in the study, the following results are observed:

SCZ pre and Age: The correlation coefficient (r) between SCZ pre scores and Age is 0.325, indicating a moderate positive correlation. The p-value (0.056) is smaller than 0.05, suggesting that this correlation is statistically significant.

SCZ pre and CAMI: The correlation coefficient between SCZ pre scores and CAMI is 0.264, indicating a moderate positive correlation. The p-value (0.205) is greater than 0.05, indicating that this correlation is not statistically significant.

SCZ pre and AU (Authoritarianism): The correlation coefficient between SCZ pre scores and AU is 0.297, indicating a moderate positive correlation. The p-value (0.056) is smaller than 0.05, suggesting that this correlation is statistically significant.

SCZ pre and BE (Benevolence): The correlation coefficient between SCZ pre scores and BE is 0.068, indicating a very weak positive correlation. The p-value (0.903) is greater than 0.05, indicating that this correlation is not statistically significant.

SCZ pre and SR (Social Restrictiveness): The correlation coefficient between SCZ pre scores and SR is 0.145, indicating a very weak positive correlation. The p-value (0.425) is greater than 0.05, indicating that this correlation is not statistically significant.

SCZ pre and CMHI (Community mental health ideology): The correlation coefficient between SCZ pre scores and CMHI is 0.084, indicating a very weak positive correlation. The p-value (0.657) is greater than 0.05, indicating that this correlation is not statistically significant.

SCZ pre and RP (Risk Propensity): The correlation coefficient between SCZ pre scores and RP is 0.303, indicating a moderate positive correlation. The p-value (0.064) is smaller than 0.05, suggesting that this correlation is statistically significant.

SCZ pre and TP (Trust propensity): The correlation coefficient between SCZ pre scores and TP is 0.55, indicating a strong positive correlation. The p-value (0.313) is smaller than 0.05, suggesting that this correlation is statistically significant.

SCZ pre and Years of Education (YOE): The correlation coefficient between SCZ pre scores and YOE is -0.156, indicating a weak negative correlation. The p-value (0.48) is greater than 0.05, indicating that this correlation is not statistically significant.

In summary, SCZ pre was significantly correlated with Age (r = 0.325*), CAMI (r = 0.264), AU (r = 0.297*), BE (r = 0.068), SR (r = 0.145), CMHI (r = 0.084), RP (r = 0.303*), and TP (r = 0.55**), indicating meaningful associations between these variables.. However, SCZ pre scores do not show significant correlations with CAMI, BE, SR, CMHI, TP, and YOE, indicating a lack of meaningful linear relationships between these variables in the sample.

*Correlation between HV pre investment and other variables*

**Table 18**

| **Variables** | **HV pre** | **Age** | **CAMI** | **AU** | **BE** | **SR** | **CMHI** | **RP** | **TP** | **Yoe** |
|---|---|---|---|---|---|---|---|---|---|---|
| **HV pre** | 1 | | | | | | | | | |
| **Age** | .252 | 1 | | | | | | | | |
| **CAMI** | .095 | .205 | 1 | | | | | | | |
| **AU** | .007 | .056 | .636** | 1 | | | | | | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **BE** | .174 | -.003 | .392** | -.043 | 1 | | | | | |
| **SR** | .014 | .184 | .717** | .224 | .077 | 1 | | | | |
| **CMHI** | .068 | .271 | .451** | .06 | -.12 | .33* | 1 | | | |
| **RP** | .39** | .095 | .013 | -.009 | -.01 | -.06 | .21 | 1 | | |
| **TP** | .63** | .313* | .286* | .183 | .05 | .21 | .21 | 0.52** | 1 | |
| **y o e** | -.047 | -.48** | .043 | .013 | .19 | .06 | -.22 | -0.12 | 0.17 | 1 |

note ** indicates a statistically significant correlation at the 0.01 level, and * indicates a statistically significant correlation at the 0.05 level.

From the above table, representing correlations between HV pre scores and other variables in the study, the following results are observed:

HV pre and Age: The correlation coefficient (r) between HV pre scores and Age is 0.252, indicating a weak positive correlation. The p-value (0.095) is smaller than 0.05, suggesting that this correlation is statistically significant.

HV pre and CAMI: The correlation coefficient between HV pre scores and CAMI is 0.095, indicating a very weak positive correlation. The p-value (0.205) is greater than 0.05, indicating that this correlation is not statistically significant.

HV pre and AU (Authoritarianism): The correlation coefficient between HV pre scores and AU is 0.007, indicating an extremely weak positive correlation. The p-value (0.056) is smaller than 0.05, suggesting that this correlation is statistically significant.

HV pre and BE (Benevolence): The correlation coefficient between HV pre scores and BE is 0.174, indicating a weak positive correlation. The p-value (0.003) is smaller than 0.05, suggesting that this correlation is statistically significant.

HV pre and SR (Social Restrictiveness): The correlation coefficient between HV pre scores and SR is 0.014, indicating a very weak positive correlation. The p-value (0.184) is greater than 0.05, indicating that this correlation is not statistically significant.

HV pre and CMHI (Community mental health ideology): The correlation coefficient between HV pre scores and CMHI is 0.068, indicating a very weak positive correlation. The p-value (0.271) is greater than 0.05, indicating that this correlation is not statistically significant.

HV pre and RP (Risk Propensity): The correlation coefficient between HV pre scores and RP is 0.39, indicating a moderate positive correlation. The p-value (0.013) is smaller than 0.05, suggesting that this correlation is statistically significant.

HV pre and TP (Trust propensity): The correlation coefficient between HV pre scores and TP is 0.63, indicating a strong positive correlation. The p-value (0.286) is smaller than 0.05, suggesting that this correlation is statistically significant.

HV pre and Years of Education (YOE): The correlation coefficient between HV pre scores and YOE is -0.047, indicating a very weak negative correlation. The p-value (0.48) is greater than 0.05, indicating that this correlation is not statistically significant.

In summary, HV pre scores show significant correlations with RP (r = 0.39**), TP (r = 0.63**) suggesting meaningful associations between these variables. However, HV pre scores do not

show significant correlations with CAMI, SR, CMHI, and YOE, indicating a lack of meaningful linear relationships between these variables in the sample.

*Correlation between SCZ post investment and other variables*

**Table 19**

| Variables | SCZ post | Age | CAMI | AU | BE | SR | CMHI | RP | TP | Yoe |
|---|---|---|---|---|---|---|---|---|---|---|
| **SCZ post** | 1 | | | | | | | | | |
| **Age** | .39** | 1 | | | | | | | | |
| **CAMI** | .344* | .205 | 1 | | | | | | | |
| **AU** | .303* | .056 | .636** | 1 | | | | | | |
| **BE** | .015 | -.003 | .392** | -.043 | 1 | | | | | |
| **SR** | .250 | .184 | .717** | .224 | .077 | 1 | | | | |
| **CMHI** | .178 | .271 | .451** | .06 | -.12 | .33* | 1 | | | |
| **RP** | .34** | .095 | .013 | -.009 | -.01 | -.06 | .21 | 1 | | |
| **TP** | .62** | .313* | .286* | .183 | .05 | .21 | .21 | 0.52** | 1 | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **y o e** | -.169 | -.48** | .043 | .013 | .19 | .06 | -.22 | -0.12 | 0.17 | 1 |

note ** indicates a statistically significant correlation at the 0.01 level, and * indicates a statistically significant correlation at the 0.05 level.

From the above table, representing correlations between SCZ post scores and other variables in the study, the following results are observed:

SCZ post and Age: The correlation coefficient (r) between SCZ post scores and Age is 0.39, indicating a moderate positive correlation. The p-value (0.01) is smaller than 0.05, suggesting that this correlation is statistically significant.

SCZ post and CAMI: The correlation coefficient between SCZ post scores and CAMI is 0.344, indicating a moderate positive correlation. The p-value (0.01) is smaller than 0.05, suggesting that this correlation is statistically significant.

SCZ post and AU (Authoritarianism): The correlation coefficient between SCZ post scores and AU is 0.303, indicating a moderate positive correlation. The p-value (0.01) is smaller than 0.05, suggesting that this correlation is statistically significant.

SCZ post and BE (Benevolence): The correlation coefficient between SCZ post scores and BE is 0.015, indicating a very weak positive correlation. The p-value is greater than 0.05, indicating that this correlation is not statistically significant.

SCZ post and SR (Social Restrictiveness): The correlation coefficient between SCZ post scores and SR is 0.25, indicating a weak positive correlation. The p-value is not smaller than 0.05, suggesting that this correlation is not statistically significant.

SCZ post and CMHI (community mental health ideology, ): The correlation coefficient between SCZ post scores and CMHI is 0.178, indicating a weak positive correlation. The p-value (0.205) is greater than 0.05, indicating that this correlation is not statistically significant.

SCZ post and RP (Risk Propensity): The correlation coefficient between SCZ post scores and RP is 0.34, indicating a moderate positive correlation. The p-value (0.01) is smaller than 0.05, suggesting that this correlation is statistically significant.

SCZ post and TP (Trust in People): The correlation coefficient between SCZ post scores and TP is 0.62, indicating a strong positive correlation. The p-value (0.01) is smaller than 0.05, suggesting that this correlation is statistically significant.

SCZ post and Years of Education (YOE): The correlation coefficient between SCZ post scores and YOE is -0.169, indicating a weak negative correlation. The p-value (0.48) is greater than 0.05, indicating that this correlation is not statistically significant.

In summary, SCZ post was significantly correlated with Age (r = 0.39**), CAMI (r = 0.344*), AU (r = 0.303*), RP (r = 0.34**), TP (r = 0.62**). However, SCZ post scores do not show a significant correlation with others, indicating a lack of meaningful linear relationships between these variables in the sample.

*Correlation between HV post investment and other variables*

**Table 20**

| Variables | HV post | Age | CAMI | AU | BE | SR | CMHI | RP | TP | Yoe |
|---|---|---|---|---|---|---|---|---|---|---|
| **HV post** | 1 | | | | | | | | | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Age** | .146 | 1 | | | | | | | | |
| **CAMI** | .179 | .205 | 1 | | | | | | | |
| **AU** | .195 | .056 | .636** | 1 | | | | | | |
| **BE** | .269 | -.003 | .392** | -.043 | 1 | | | | | |
| **SR** | .084 | .184 | .717** | .224 | .077 | 1 | | | | |
| **CMHI** | .024 | .271 | .451** | .06 | -.12 | .33* | 1 | | | |
| **RP** | .267 | .095 | .013 | -.009 | -.01 | -.06 | .21 | 1 | | |
| **TP** | .47** | .313* | .286* | .183 | .05 | .21 | .21 | 0.52** | 1 | |
| **y o e** | -.017 | -.48** | .043 | .013 | .19 | .06 | -.22 | -0.12 | 0.17 | 1 |

Note ** indicates a statistically significant correlation at the 0.01 level, and * indicates a statistically significant correlation at the 0.05 level.

From the above table, representing correlations between SCZ post scores and other variables in the study, the following results are observed:

HV post and Age: The correlation coefficient (r) between HV post scores and Age is 0.146, indicating a very weak positive correlation. The p value is above 0.05 thus the relationship is not statistically significant.

HV post and CAMI: The correlation coefficient between HV post scores and CAMI is 0.179, indicating a weak positive correlation. The p value is above 0.05 thus the relationship is not statistically significant.

HV post and AU (Authoritarianism): The correlation coefficient between HV post scores and AU is 0.195, indicating a weak positive correlation. The p-value is not smaller than 0.05, suggesting that this correlation is not statistically significant.

HV post and BE (Benevolence): The correlation coefficient between HV post scores and BE is 0.269, indicating a moderate positive correlation. The p-value is not smaller than 0.01, suggesting that this correlation is not statistically significant.

HV post and SR (Social Restrictiveness): The correlation coefficient between HV post scores and SR is 0.084, indicating a very weak positive correlation. The p value is above 0.05 thus the relationship is not statistically significant.

HV post and CMHI (Community mental health ideology): The correlation coefficient between HV post scores and CMHI is 0.024, indicating a very weak positive correlation. The p value is above 0.05 thus the relationship is not statistically significant.

HV post and RP (Risk Propensity): The correlation coefficient between HV post scores and RP is 0.267, indicating a moderate positive correlation. The p-value is not smaller than 0.05, suggesting that this correlation is not statistically significant.

HV post and TP (Trust): The correlation coefficient between HV post scores and TP is 0.47, indicating a strong positive correlation. The p-value is smaller than 0.01, suggesting that this correlation is statistically significant.

HV post and Years of Education (YOE): The correlation coefficient between HV post scores and YOE is -0.017, indicating a very weak negative correlation. The p value is above 0.05 thus the relationship is not statistically significant.

In conclusion, HV post was significantly correlated with only trust propensity TP (r = 0.47**).

*Correlation between Pre total investment and other variables*

**Table 21**

| **Variables** | **Pre total** | **Age** | **CAMI** | **AU** | **BE** | **SR** | **CMHI** | **RP** | **TP** | **Yoe** |
|---|---|---|---|---|---|---|---|---|---|---|
| **Pre total** | 1 | | | | | | | | | |
| **Age** | .340 | 1 | | | | | | | | |
| **CAMI** | .216 | .205 | 1 | | | | | | | |
| **AU** | .188 | .056 | .636** | 1 | | | | | | |
| **BE** | .138 | -.003 | .392** | -.043 | 1 | | | | | |
| **SR** | .098 | .184 | .717** | .224 | .077 | 1 | | | | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **CMHI** | .090 | .271 | .451** | .06 | -.12 | .33* | 1 | | | |
| **RP** | .404** | .095 | .013 | -.009 | -.01 | -.06 | .21 | 1 | | |
| **TP** | .69** | .313* | .286* | .183 | .05 | .21 | .21 | 0.52** | 1 | |
| **y o e** | -.123 | -.48** | .043 | .013 | .19 | .06 | -.22 | -0.12 | 0.17 | 1 |

Note ** indicates a statistically significant correlation at the 0.01 level, and * indicates a statistically significant correlation at the 0.05 level.

From the above table, representing correlations between pre total scores and other variables in the study, the following results are observed:

Pre total and Age: This indicates a moderate positive correlation between Pre total and Age, meaning that as age increases, the Pre total score tends to increase. The correlation is statistically significant (p-value less than 0.05).

Pre total and CAMI: There is a positive correlation between Pre total and CAMI scores, suggesting that as the CAMI score increases, the Pre total score also tends to increase. This correlation is statistically significant (p-value less than 0.05).

Pre total and AU A positive correlation exists between Pre total and AU scores, implying that as the AU score increases, the Pre total score tends to increase. This correlation is statistically significant (p-value less than 0.05).

Pre total and BE There is a positive correlation between Pre total and BE scores, indicating that as the BE score increases, the Pre total score also tends to increase. This correlation is statistically significant (p-value less than 0.05).

Pre total and SR - The correlation between Pre total and SR scores is positive, suggesting that as the SR score increases, the Pre total score tends to increase as well. However, this correlation is not statistically significant (p-value greater than 0.05).

Pre total and CMHI - There is a positive correlation between Pre total and CMHI scores, indicating that as the CMHI score increases, the Pre total score tends to increase. However, this correlation is not statistically significant (p-value greater than 0.05).

Pre total and RP - A strong positive correlation exists between Pre total and RP scores. As the RP score increases, the Pre total score tends to increase as well. This correlation is statistically significant (p-value less than 0.01),

*Correlation between Post total investment and other variables*

**Table 22**

| **Variables** | **Post total** | **Age** | **CAMI** | **AU** | **BE** | **SR** | **CMHI** | **RP** | **TP** | **Yoe** |
|---|---|---|---|---|---|---|---|---|---|---|
| **Post total** | 1 | | | | | | | | | |
| **Age** | .39** | 1 | | | | | | | | |
| **CAMI** | .28* | .205 | 1 | | | | | | | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **AU** | .213 | .056 | .636** | 1 | | | | | | |
| **BE** | .094 | -.003 | .392** | -.043 | 1 | | | | | |
| **SR** | .179 | .184 | .717** | .224 | .077 | 1 | | | | |
| **CMHI** | .156 | .271 | .451** | .06 | -.12 | .33* | 1 | | | |
| **RP** | .42** | .095 | .013 | -.009 | -.01 | -.06 | .21 | 1 | | |
| **TP** | .73** | .313* | .286* | .183 | .05 | .21 | .21 | 0.52** | 1 | |
| **y o e** | -.139 | -.48** | .043 | .013 | .19 | .06 | -.22 | -0.12 | 0.17 | 1 |

note ** indicates a statistically significant correlation at the 0.01 level, and * indicates a statistically significant correlation at the 0.05 level.

From the above table, representing correlations between post total scores and other variables in the study, the following results are observed:

Post total and Age: There is a strong positive correlation between Post total and Age scores, indicating that as age increases, the Post total score tends to increase significantly. This correlation is statistically significant (p-value less than 0.01).

Post total and CAMI- There is a moderate positive correlation between Post total and CAMI scores, suggesting that as the CAMI score increases, the Post total score tends to increase. This correlation is statistically significant (p-value less than 0.05).

Post total and AU - A positive correlation exists between Post total and AU scores, indicating that as the AU score increases, the Post total score tends to increase. However, this correlation is not statistically significant (p-value greater than 0.05).

Post total and BE -There is a positive correlation between Post total and BE scores, suggesting that as the BE score increases, the Post total score tends to increase. However, this correlation is not statistically significant (p-value greater than 0.05).

Post total and SR (Social Restrictiveness): A positive correlation exists between Post total and SR scores, indicating that as the SR score increases, the Post total score tends to increase. However, this correlation is not statistically significant (p-value greater than 0.05).

Post total and CMHI (Community Mental Health Ideology): There is a positive correlation between Post total and CMHI scores, suggesting that as the CMHI score increases, the Post total score tends to increase. However, this correlation is not statistically significant ($r = 0.156$, $p > 0.05$)

Post total and RP (Authoritarianism): There is a strong positive correlation between Post total and RP scores, indicating that as the RP score increases, the Post total score tends to increase significantly. This correlation is statistically significant ($r = 0.42^{**}$, $p < 0.01$).

Post total and TP (trust propensity): There is a very strong positive correlation between Post total and TP scores, suggesting that as the TP score increases, the Post total score tends to increase significantly. This correlation is statistically significant ($r = 0.73^{**}$, $p < 0.01$).

Post total and y o e (Years of Education):. There is a negative correlation between Post total and y o e scores, indicating that as the y o e score increases, the Post total score tends to decrease slightly. However, this correlation is not statistically significant ( $r = -0.139$, $p > 0.05$).

*Correlation between total investment and other variables*

**Table 23**

| Variables | TI | Age | CAMI | AU | BE | SR | CMHI | RP | TP | Yoe |
|---|---|---|---|---|---|---|---|---|---|---|
| **TI** | 1 | | | | | | | | | |
| **Age** | .306* | 1 | | | | | | | | |
| **CAMI** | .232 | .205 | 1 | | | | | | | |
| **AU** | .249 | .056 | .636** | 1 | | | | | | |
| **BE** | .098 | -.003 | .392** | -.043 | 1 | | | | | |
| **SR** | .086 | .184 | .717** | .224 | .077 | 1 | | | | |
| **CMHI** | .107 | .271 | .451** | .06 | -.12 | .33* | 1 | | | |
| **RP** | .42** | .095 | .013 | -.009 | -.01 | -.06 | .21 | 1 | | |
| **TP** | .74** | .313* | .286* | .183 | .05 | .21 | .21 | 0.52** | 1 | |
| **y o e** | -.098 | -.48** | .043 | .013 | .19 | .06 | -.22 | -0.12 | 0.17 | 1 |

note ** indicates a statistically significant correlation at the 0.01 level, and * indicates a statistically significant correlation at the 0.05 level. TI is total investment

From the above table, representing correlations between total investment scores and other variables in the study, the following results are observed:

Total investment and Age: There is a moderate positive correlation between Total investment and Age scores, indicating that as age increases, the Total investment score tends to increase. This correlation is statistically significant ($r = 0.306^*$, $p < 0.05$ ).

Total investment and stigma: A positive correlation exists between Total investment and cami scores, suggesting that as the stigma score increases, the Total investment score tends to increase. However, this correlation is not statistically significant ($r = 0.232$, $p > 0.05$).

Total investment and AU (Authoritarianism): There is a positive correlation between Total investment and AU scores, indicating that as the AU score increases, the Total investment score tends to increase. However, this correlation is not statistically significant ($r = 0.249$, $p > 0.05$).

Total investment and BE (Benevolence): There is a positive correlation between Total investment and BE scores, suggesting that as the BE score increases, the Total investment score tends to increase. However, this correlation is not statistically significant ($r = 0.098$, $p > 0.05$).

Total investment and SR (Social Restrictiveness): A positive correlation exists between Total investment and SR scores, indicating that as the SR score increases, the Total investment score tends to increase. However, this correlation is not statistically significant ($r = 0.086$, $p > 0.05$).

Total investment and CMHI (Community Mental Health Ideology): There is a positive correlation between Total investment and CMHI scores, suggesting that as the CMHI score

increases, the Total investment score tends to increase. However, this correlation is not statistically significant ($r = 0.107$, $p > 0.05$).

Total investment and RP (risk propensity): There is a strong positive correlation between Total investment and RP scores, indicating that as the RP score increases, the Total investment score tends to increase significantly. This correlation is statistically significant ($r = 0.42^{**}$, $p < 0.01$).

Total investment and TP (trust propensity):There is a very strong positive correlation between Total investment and TP scores, suggesting that as the TP score increases, the Total investment score tends to increase significantly. This correlation is statistically significant ($r = 0.74^{**}$, $p < 0.01$).

Total investment and y o e (Years of Education): There is a negative correlation between Total investment and y o e scores, implying that as the y o e score increases, the Total investment score tends to decrease slightly. However, this correlation is not statistically significant ($r = 0.098$, $p > 0.05$).

In conclusion, Significant correlations ($p < 0.05$) were observed between Total Investment (TI) and Age ($r = 0.306^{*}$), RP ($r = 0.42^{**}$), TP ($r = 0.74$.

*Correlation between stigma, age, risk propensity, trust propensity*

**Table 24**

| Variables | M | SD | Stigma | Age | RP | TP |
|---|---|---|---|---|---|---|
| **Stigma** | 8.55 | 1.68 | 1 | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Age** | 23.12 | 10.91 | .205 | 1 | | |
| **RP** | 71.59 | 29.03 | .013 | .095 | 1 | |
| **TP** | 59.92 | 26.71 | .286* | .313* | .52** | 1 |

note ** indicates a statistically significant correlation at the 0.01 level, and * indicates a statistically significant correlation at the 0.05 level.

Age and RP: The correlation coefficient between Age and RP was 0.013. This indicates a very weak positive relationship between participants' ages and Risk propensity, which is not statistically significant ($p > 0.05$).

Age and TP: The correlation coefficient between Age and TP was 0.095. Again, this suggests a very weak positive correlation that is not statistically significant ($p > 0.05$).

RP and TP: The correlation coefficient between RP and TP was 0.52, which indicates a moderate positive relationship. This correlation is statistically significant at the 0.01 level.

Stigma and Age: The correlation coefficient between Stigma and Age was 0.205, revealing a weak positive correlation between age and perceived stigma. However, this correlation is not statistically significant ($p > 0.05$).

Stigma and RP: The correlation coefficient between Stigma and RP was 0.286. This moderate negative correlation suggests that higher levels of perceived stigma are associated with reduced risk propensity. This correlation is statistically significant at the 0.01 level.

Stigma and TP: The correlation coefficient between Stigma and TP was 0.313. Similarly, this moderate negative correlation implies that higher levels of perceived stigma are linked to lower trust propensity This correlation is statistically significant at the 0.01 level.

Overall, the comprehensive analysis suggests that in baseline condition, while there are some similarities in the factors influencing SCZ Investment and HV Investment, there are also notable differences. Age and authoritarianism appear to have a more significant impact on SCZ Investment, and not in HV Investment. Risk Propensity and Trust Propensity play similar roles in influencing investments in both the person with schizophrenia and the healthy person.

In the feedback condition, while risk propensity and trust propensity consistently influence both pre and post feedback investments, age, authoritarianism, and stigma appear to be more relevant in shaping investment decisions regarding individuals with schizophrenia (SCZ) before and after feedback. Age and authoritarianism attitude appear to have a more significant impact on pre and post SCZ Investment, and not in pre and post HV Investment. Cami is negatively correlated with post feedback investments in the person with schizophrenia (SCZ Post), indicating that people with considerably positive attitude towards PLWSCZ invested more after getting feedback from them.

## Figure no 17 Correlation matrix

| | age | E | G | R | S | risk | STIGMA | AU | BE | SR | CMHI | RP | TP | SCZ | HV | SCZ_p | HV_P | SCZ_Po | HV_Po | SCZ_T | HV_T | Pre_t | Post_T | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| age | 1 | | | | | | | | | | | | | | | | | | | | | | | |
| E | 0.5 | 1 | | | | | | | | | | | | | | | | | | | | | | |
| G | 0.28 | 0.3 | 1 | | | | | | | | | | | | | | | | | | | | | |
| R | 0.1 | 0.1 | 0.2 | 1 | | | | | | | | | | | | | | | | | | | | |
| S | 0.2 | 0.1 | 0.29 | 0.1 | 1 | | | | | | | | | | | | | | | | | | | |
| risk | 0.14 | 0.06 | 0.1 | 0.2 | 0.2 | 1 | | | | | | | | | | | | | | | | | | |
| STIGMA | 0.21 | 0.04 | 0.03 | 0 | 0.19 | 0.1 | 1 | | | | | | | | | | | | | | | | | |
| AU | 0.06 | 0.01 | 0.05 | 0.2 | 0.1 | 0 | 0.6 | 1 | | | | | | | | | | | | | | | | |
| BE | 0 | 0.19 | 0.2 | 0 | 0.2 | 0.2 | 0.4 | 0 | 1 | | | | | | | | | | | | | | | |
| SR | 0.18 | 0.06 | 0.08 | 0.1 | 0.07 | 0.2 | 0.7 | 0.22 | 0.08 | 1 | | | | | | | | | | | | | | |
| CMHI | 0.27 | 0.2 | 0.14 | 0 | 0.03 | 0 | 0.5 | 0.06 | 0.1 | 0.33 | 1 | | | | | | | | | | | | | |
| RP | 0.07 | 0.1 | 0.1 | 0 | 0.03 | 0.1 | 0 | 0 | 0 | 0.1 | 0.21 | 1 | | | | | | | | | | | | |
| TP | 0.31 | 0.2 | 0.1 | 0.1 | 0.06 | 0.1 | 0.3 | 0.18 | 0.05 | 0.21 | 0.21 | 0.52 | 1 | | | | | | | | | | | |
| SCZ | 0.34 | 0.1 | 0.07 | 0.1 | 0.13 | 0 | 0.2 | 0.34 | 0.1 | 0.09 | 0.12 | 0.34 | 0.57 | 1 | | | | | | | | | | |
| HV | 0.07 | 0.1 | 0.11 | 0 | 0.19 | 0 | 0.2 | 0.09 | 0.24 | 0.03 | 0.06 | 0.32 | 0.62 | 0.28 | 1 | | | | | | | | | |
| SCZ_p | 0.32 | 0.2 | 0.04 | 0.1 | 0.09 | 0 | 0.3 | 0.3 | 0.07 | 0.15 | 0.08 | 0.31 | 0.55 | 0.88 | 0.3 | 1 | | | | | | | | |
| HV_P | 0.24 | 0 | 0.26 | 0 | 0.19 | 0.1 | 0.1 | 0.01 | 0.17 | 0.01 | 0.07 | 0.4 | 0.63 | 0.42 | 0.8 | 0.46 | 1 | | | | | | | |
| SCZ_Po | 0.4 | 0.2 | 0.01 | 0 | 0.11 | 0 | 0.3 | 0.3 | 0.01 | 0.25 | 0.18 | 0.33 | 0.62 | 0.78 | 0.4 | 0.81 | 0.43 | 1 | | | | | | |
| HV_Po | 0.14 | 0 | 0.1 | 0 | 0.21 | 0 | 0.2 | 0.2 | 0.27 | 0.1 | 0.02 | 0.27 | 0.47 | 0.46 | 0.7 | 0.46 | 0.71 | 0.36 | 1 | | | | | |
| SCZ_T | 0.34 | 0.1 | 0.06 | 0.1 | 0.12 | 0 | 0.2 | 0.33 | 0.1 | 0.11 | 0.11 | 0.34 | 0.58 | 0.99 | 0.3 | 0.94 | 0.44 | 0.81 | 0.48 | 1 | | | | |
| HV_T | 0.13 | 0 | 0.17 | 0 | 0.2 | 0.1 | 0.2 | 0.06 | 0.23 | 0.03 | 0.07 | 0.36 | 0.65 | 0.34 | 1 | 0.38 | 0.91 | 0.43 | 0.74 | 0.37 | 1 | | | |
| Pre_t | 0.33 | 0.1 | 0.17 | 0 | 0.16 | 0 | 0.2 | 0.19 | 0.14 | 0.1 | 0.09 | 0.41 | 0.69 | 0.78 | 0.6 | 0.87 | 0.83 | 0.74 | 0.68 | 0.83 | 0.74 | 1 | | |
| Post_T | 0.39 | 0.1 | 0.13 | 0 | 0.16 | 0 | 0.3 | 0.21 | 0.09 | 0.18 | 0.16 | 0.42 | 0.73 | 0.74 | 0.7 | 0.78 | 0.78 | 0.9 | 0.59 | 0.78 | 0.74 | 0.92 | 1 | |
| Total | 0.3 | 0.1 | 0.13 | 0 | 0.19 | 0 | 0.2 | 0.25 | 0.1 | 0.09 | 0.11 | 0.42 | 0.74 | 0.83 | 0.7 | 0.82 | 0.8 | 0.77 | 0.72 | 0.85 | 0.8 | 0.95 | 0.92 | 1 |

Figure 17

**Regression analysis of SCZ and other variables**

*Regression of association between SCZ investment and age*

**Table 25**

| Variable | B | SE | T | p |
|---|---|---|---|---|
| Age | 1.085 | 0.422 | 2.569 | 0.01 |

Note SCZ is investment in individual with schizophrenia in phase 1

Based on the linear regression analysis, the relationship between age and investment in individuals with schizophrenia (SCZ) was examined. The age coefficient of 1.085 suggests that for every one unit increase in age, there is an associated increase of 1.085 units in investment towards individuals with schizophrenia. The positive coefficient indicates that older participants tend to invest more in individuals with schizophrenia compared to younger participants.

The standardized coefficient (Beta) for age is 0.341. This indicates a moderate effect of age on investment in individuals with schizophrenia. The positive Beta value further supports the conclusion that age has a positive relationship with investment in SCZ.

As people age, they might demonstrate higher pro social behaviour and compassion towards others, including those with mental health conditions like schizophrenia. This could have driven older individuals to invest more in SCZ. Research suggests that elderly individuals are more inclined towards prosocial actions and display higher levels of care for others compared to younger adults, as demonstrated by studies conducted by (Cutler et al. 2021, Mayr & Freund 2020, and Sparrow et al. 2021).

Also, with increasing age, individuals may have had more opportunities for exposure to diverse experiences, including encounters with mental health issues. This exposure might lead to greater understanding and awareness, which in turn can influence investment decisions.

Regression of association between SCZ investment and AU

**Table 26**

| **Variable** | **B** | **SE** | **T** | **p** |
|---|---|---|---|---|
| AU | 3.804 | 1.554 | 2.448 | . 01 |

Note : AU is authoritarianism, SCZ is investment in individual with schizophrenia in phase 1

The coefficient for the authoritarianism variable is 3.804. It suggests that for every one unit increase in authoritarianism, there is an associated increase of 3.804 units in investment in individuals with schizophrenia (SCZ). The Beta value of 0.336 indicates that the effect of authoritarianism on SCZ is moderate. The p value of 0.018 indicates that there is a statistically significant relationship between SCZ and authoritarianism.

*Regression of association between SCZ investment and SR*

**Table 27**

| **Variable** | **B** | **SE** | **T** | **p** |
|---|---|---|---|---|
| SR | 40.729 | 13.61 | 2.991 | 0.004 |

Note SR is social restrictiveness, SCZ is investment in individual with schizophrenia in phase 1

In the above regression analysis, the results shows that there is a significant effect as the p value is below the conventional value. The B value (Beta coefficient) is 40.729, indicating that for every one unit increase in authoritarianism, there is an associated increase of 3.804 units in investment in individuals with schizophrenia (SCZ).

The SE value represents the standard error of the Beta coefficient, which is 13.61. The T value (t statistic) is 2.991. The p value associated with the t statistic is 0.004. Since the p value (0.004) is less than 0.05, it can be concluded that there is a statistically significant effect of SR on the SCZ investment.

**Regression analysis of HV and other variables**

Regression of association between HV investment and Age

**Table 28**

| Variable | B | SE | T | p |
|---|---|---|---|---|
| Age | 0.211 | 0.398 | 0.529 | 0.60 |

Note HV is investment in healthy individual in phase 1

The coefficient for the age variable is 0.211. It suggests that for every one unit increase in age, there is an associated increase of 0.211 units in the HV but as the p value is above 0.05, it can be concluded that there is no significant relationship between the two.

*Regression of association between HV investment and AU*

**Table 29**

| Variable | B | SE | T | p |
|---|---|---|---|---|
| AU | 0.852 | 1.456 | 0.585 | 0.56 |

Note AU is authoritarianism, HV is investment in healthy individual in phase 1

The coefficient for the authoritarianism variable is 0.852. It suggests that for every one unit increase in authoritarianism, there is an associated increase of 0.852 units in investment in healthy volunteers (HV). The p value of 0.561 indicates that there is no statistically significant relationship between authoritarianism and investment in healthy individual HV.

*Regression of association between HV investment and SR*

**Table 30**

| Variable | B | SE | T | p |
|---|---|---|---|---|
| Social restrictiveness | 7.597 | 13.122 | 0.579 | 0.565 |

Note HV is investment in healthy individual in phase 1

The beta coefficient is 7.597 which implies that a one unit change in Social restrictiveness is associated with an estimated change of 7.597 units in the dependent variable. The standard error for the coefficient estimate of Social restrictiveness is 13.122. The t value is 0.579 and the p value is 0.565 suggesting no significance.

Regression of association between SCZ pre feedback investment and Age

**Table 31**

| **Variable** | **B** | **SE** | **T** | **p** |
|---|---|---|---|---|
| Age | 0.493 | 0.210 | 2.353 | 0.02 |

Note SCZ pre is investment in SCZ before feedback

The linear regression model above shows the association between SCZ_pre I.e., investment in the individual with schizophrenia before feedback condition and age. The coefficient for the age variable is 0.493. It suggests that for every one unit increase in age, there is an associated increase of 0.493 units in SCZ_pre. The Beta value of 0.316 indicates that the effect of age on SCZ_pre is moderate. As the p value is below 0.05, the relationship is said to be statistically significant.

*Regression of association between SCZ pre investment and AU*

**Table 32**

| Variable | B | SE | T | p |
|---|---|---|---|---|
| AU | 1.652 | 0.774 | 2.134 | 0.03 |

Note AU is authoritarianism, SCZ pre is investment in SCZ before feedback

The coefficient for the authoritarianism variable is 1.652. It suggests that for every one unit increase in authoritarianism, there is an associated increase of 1.652 units in investment in individual with schizophrenia before receiving feedback (SCZ_pre). The Beta value of 0.297 indicates that the effect of authoritarianism on SCZ_pre is moderate. The p value of 0.03 indicates that there is a statistically significant relationship between authoritarianism and SCZ_pre.

*Regression of association between SCZ pre investment and SR*

**Table 33**

| Variable | B | SE | T | p |
|---|---|---|---|---|
| SR | 15.070 | 6.962 | 2.165 | 0.03 |

Note SR is Social restrictiveness, SCZ pre is investment in SCZ before feedback

In the above regression analysis, the results indicate that the variable Social Restrictiveness (SR) has a statistically significant effect on SCZ pre scores. The negative regression coefficient

(B = 15.070) suggests that as the level of Social Restrictiveness (SR) increases, the outcome variable (e.g., SCZ pre scores) tends to decrease. The t value of 2.165 indicates the magnitude of the relationship, and the p value of 0.03 indicates that this relationship is statistically significant at the conventional significance level of 0.05.

It means that higher levels of social restrictiveness, where individuals believe that mentally ill patients are a threat to society and should be avoided, are associated with lower scores related to SCZ pre.

Regression of association between HV pre investment and age.

**Table 34**

| **Variable** | **B** | **SE** | **T** | **p** |
|---|---|---|---|---|
| Age | 0.34 | 0.191 | 1.784 | 0.08 |

Note HV pre is investment in health individual before feedback condition

The results indicate that there is a positive regression coefficient of 0.34, suggesting a positive relationship between age and investment in HV pre. However, the t value of 1.784 and the p value of 0.08 indicate that this relationship is not statistically significant at the conventional significance level of 0.05.

*Regression of association between HV pre investment and AU*

**Table 35**

| Variable | B | SE | T | p |
|---|---|---|---|---|
| AU | 0.037 | 0.721 | 0.051 | 0.960 |

Note AU is authoritarianism and HV pre is investment in health individual before feedback session

The coefficient for the authoritarianism variable is 0.037. It suggests that for every one unit increase in authoritarianism, there is an associated increase of 0.037 units in investment in healthy volunteers before feedback (HV_Pre). The p value of 0.960 indicates that there is no statistically significant relationship between authoritarianism and HV_Pre.

*Regression of association between HV pre investment and Benevolence*

*Table 36*

| Variable | B | SE | T | p |
|---|---|---|---|---|
| BE | 8.66 | 4.090 | 2.117 | 0.04 |

Note BE is benevolence and HV pre is investment in health individual before feedback session

The unstandardized coefficient (B) is 8.660, with a standard error of 4.090. The Beta value (standardized coefficient) is 0.295. The t value (2.117) and significance level (.040) indicate that this predictor is statistically significant. Also, multicollinearity doesn't appear to be a concern based on the Tolerance and VIF values.

*Regression of association between SCZ post investment and age*

**Table 37**

| Variable | B | SE | T | p |
|---|---|---|---|---|
| Age | 0.766 | 0.259 | 2.955 | 0.005 |

Note – SCZ post is investment in individual living with schizophrenia after feedback condition

The coefficient for the age variable is 0.764. It suggests that for every one unit increase in age, there is an associated increase of 0.764 units in SCZ_Post. The Beta value of 0.398 indicates that the effect of age on SCZ_Post is moderate. The findings show that age has a statistically significant effect on SCZ_Post ($p = 0.004$). Also, multicollinearity doesn't appear to be a concern based on the Tolerance and VIF values.

*Regression of association between SCZ post investment and AU*

**Table 38**

| Variable | B | SE | T | p |
|---|---|---|---|---|
| AU | 2.149 | 0.985 | 2.182 | 0.03 |

Note AU is authoritarianism, SCZ post is investment in individual living with schizophrenia after feedback condition

The coefficient for the authoritarianism variable is 2.149 with a standard error of 0.985. The t value is 2.182, and the associated p value is 0.034. The coefficient is positive, suggesting that higher levels of authoritarianism are associated with increased investment in individuals with schizophrenia after reciprocity feedback condition. Additionally, the p value is less than 0.05, indicating that the authoritarianism coefficient is statistically significant at 5% level. Also, multicollinearity doesn't appear to be a concern based on the Tolerance and VIF values.

*Regression of association between SCZ post investment and SR*

**Table 39**

| Variable | B | SE | T | p |
|---|---|---|---|---|
| SR | 24.641 | 8.585 | 2.872 | 0.006 |

Note SR is social restrictiveness, SCZ post is investment in individual living with schizophrenia after feedback condition

The results indicate that there is a negative regression coefficient of 24.641, suggesting a negative relationship between investment in HV post feedback and social restrictiveness (SR). The t value of 2.872 and the p value of 0.006 indicate that this relationship is statistically significant at the conventional significance level of 0.05. These findings imply that individuals who are higher in social restrictiveness are more likely to invest less in SCZ after receiving feedback. Also, multicollinearity doesn't appear to be a concern based on the Tolerance and VIF values.

*Regression of association between HV post investment and Age*

**Table 40**

| Variable | B | SE | T | p |
|---|---|---|---|---|
| Age | 0.224 | 0.220 | 1.015 | 0.315 |

HV post is investment in healthy individual after feedback condition

The coefficient for the age variable is 0.217. It suggests that for every one unit increase in age, there is an associated increase of 0.217 units HV_Post. The Beta value of 0.143 indicates that the effect of age on HV_Post is small. The p value of 0.322 indicates that there is no significant relationship between age and HV post.

*Regression of association between HV post investment and AU*

**Table 41**

| Variable | B | SE | T | p |
|---|---|---|---|---|
| AU | 1.091 | 0.80 | 1.364 | 0.179 |

Note AU is authoritarianism, HV post is investment in healthy individual after feedback condition

The coefficient for authoritarianism variable is 1.091 with a standard error of 0.800. The t value is 1.364, and the associated p value is 0.179. The coefficient is positive, suggesting that higher levels of authoritarianism are associated with increased investment in HV_Post. However, the p value is greater than 0.05, indicating that the authoritarianism coefficient is not statistically

significant at the 5% level. The lack of statistical significance may indicate that other factors could be influencing investment in healthy individuals post feedback.

*Regression of association between HV post investment and BE*

**Table 21**

| Variable | B | SE | T | p |
|---|---|---|---|---|
| BE | 10.303 | 4.601 | 2.239 | 0.030 |

BE is beneviolence, HV post is investment in healthy individual after feedback condition

The beta coefficient estimate for authoritarianism is 1.091 and the standard error is 0.80.The t value is1.364 and the corresponding p value is 0.179. Since the p value (0.179) is greater than the common significance level of 0.05, this suggests that there is not statistically significantly association between the two variables.

*Regression of association between SCZ total investment and Age*

**Table 22**

| Variable | B | SE | T | p |
|---|---|---|---|---|
| AGE | 1.578 | 0.612 | 2.577 | 0.013 |

Note SCZ total is investment in individual with schizophrenia in total

The coefficient for the age variable is 1.521. It suggests that for every one unit increase in age, there is an associated increase of 1.521 units in SCZ_Total. The Beta value of 0.342 indicates that the effect of age on SCZ_Total is moderate. The findings show that age has a statistically significant effect on SCZ_Total (p = 0.015). Also, multicollinearity doesn't appear to be a concern based on the Tolerance and VIF values.

*Regression of association between SCZ total investment and AU*

**Table 23**

| Variable | B | SE | T | p |
|---|---|---|---|---|
| AU | 5.456 | 2.257 | 2.417 | 0.020 |

Note AU is authoritarianism, SCZ total is investment in individual with schizophrenia in total

The coefficient for the authoritarianism variable is 5.456. It suggests that for every one unit increase in authoritarianism, there is an associated increase of 5.456 units SCZ_Total. The Beta value of 0.332 indicates that the effect of authoritarianism on SCZ total is moderate. The p value of 0.020 indicates that there is a significant relationship between authoritarianism and total SCZ investment. Also, multicollinearity doesn't appear to be a concern based on the Tolerance and VIF values.

Authoritarian individuals may be driven by a desire for control and power. In the trust game context, they may see investing more in SCZ as a way to exert control over individuals they perceive as inferior or in need of supervision.

Authoritarianism is associated with a preference for a hierarchical social structures. Investing more in SCZ scenarios may reflect a desire to maintain hierarchical relationships, with authoritarian individuals positioning themselves as superior decisionmakers.

*Regression of association between SCZ total investment and SR*

*Table 24*

| **Variable** | **B** | **SE** | **T** | **p** |
|---|---|---|---|---|
| SR | 55.798 | 19.959 | 2.796 | 0.007 |

Note SR is social restrictiveness, SCZ total is investment in individual with schizophrenia in total

The results indicate that suggesting a negative relationship between social restrictiveness (SR) and total investment in SCZ. Beta coefficient is  55.798. The t value of 2.796 and the p value of 0.007 indicate that this relationship is statistically significant at the conventional significance level of 0.05. These findings imply that individuals who hold higher levels of social restrictiveness are more likely to invest less in SCZ. Also, multicollinearity doesn't appear to be a concern based on the Tolerance and VIF values.

*Regression of association between HV total investment and age*

*Table 25*

| **Variable** | **B** | **SE** | **T** | **p** |
|---|---|---|---|---|
| Age | 0.551 | 0.556 | 0.973 | 0.33 |

Note HV total is investment in healthy individual in total

The above regression model suggest that the unstandardized coefficient (B) is 0.551, with a standard error of 0.566. The Beta value (standardized coefficient) is 0.141. The t value (0.973) and significance level (.335) suggest that this predictor is not statistically significant.

*Regression of association between HV total investment and authoritarianism*

**Table 26**

| **Variable** | **B** | **SE** | **T** | **p** |
|---|---|---|---|---|
| AU | 0.889 | 2.088 | 0.426 | 0.67 |

Note AU is authoritarianism, Note HV total is investment in healthy individual in total

The coefficient for the authoritarianism variable is 0.889. It suggests that for every one unit increase in authoritarianism, there is an associated increase of 0.889 units in the total investment in HV_Total. The Beta value of 0.062 indicates that the effect of authoritarianism on HV_Total is negligible. The p value of 0.672 indicates that there is no statistically significant relationship between authoritarianism and HV_Total in this context.

**Regression between pre total and other variables**

*Regression of association between pre total investment and authoritarianism*

**Table 27**

| Variable | B | BE | T | p |
|---|---|---|---|---|
| AU | 0.833 | 0.336 | 2.479 | 0.017 |

Note AU is authoritarianism

The coefficient for the authoritarianism variable is 0.833. It suggests that for every one unit increase in authoritarianism, there is an associated increase of 0.833 units in the total investment in pre_Total. The Beta value of 0.336 indicates that the effect of authoritarianism on pre_Total is negligible. The p value of 0.01 indicates that there is statistically significant relationship between age and pre_Total. Multicollinearity doesn't appear to be a concern based on the Tolerance and VIF values.

**Regression between post total and other variables**

*Regression of association between post total investment and authoritarianism*

*Table 28*

| Variable | B | SE | T | p |
|---|---|---|---|---|
| AU | 1.107 | 0.376 | 2.942 | 0.005 |

Note AU is authoritarianism

The unstandardized coefficient (B) is 1.107, with a standard error of 0.376. The Beta value (standardized coefficient) is 0.394. The t value (2.942) and significance level (.005) indicate that this predictor is statistically significant, as the p value is less than the chosen significance

level (0.05). Multicollinearity doesn't appear to be a concern based on the Tolerance and VIF values.

*Regression of association between post total investment and authoritarianism*

**Table 29**

| Variable | B | SE | T | p |
|---|---|---|---|---|
| AU | 1.560 | 0.772 | 2.022 | 0.04 |

Note AU is authoritarianism

The unstandardized coefficient (B) is 1.560, with a standard error of 0.772. The Beta value (standardized coefficient) is 0.283. The t value (2.022) and significance level (.049) indicate that this predictor is statistically significant at the 0.05 level, as the p value is less than the chosen significance level (0.05). Multicollinearity doesn't appear to be a concern based on the Tolerance and VIF values.

**Regression between total investment and other variables**

*Regression of association between total investment and age*

**Table 30**

| Variable | B | SE | T | p |
|---|---|---|---|---|
| Age | 2.129 | 0.965 | 2.206 | 0.03 |

The unstandardized coefficient (B) is 2.129, with a standard error of 0.965. The Beta value (standardized coefficient) is 0.306. The t value (2.206) and significance level (.032) indicate that this predictor is statistically significant at the 0.05 level. Multicollinearity doesn't appear to be a concern based on the Tolerance and VIF values.

**Regression between stigma and trust propensity**

*Regression of association between stigma and trust propensity*

Table 31

| **Variable** | **B** | **SE** | **T** | **p** |
|---|---|---|---|---|
| Trust propensity | -0.055 | 0.02 | 2.046 | 0.04 |

The standardized coefficient (Beta) for the Trust Propensity variable is -0.286. The t-value associated with the coefficient for Trust Propensity is 2.046. The p-value is 0.046. since the p-value is less than 0.05, the association between stigma and trust propensity is statistically significant. Specifically, as Trust Propensity increases, there is an associated decrease in individuals' stigma, as indicated by the negative coefficient (B = -0.055) and the negative standardized coefficient (Beta = -0.286).

In summary, Specifically, in the overall analysis, age and authoritarianism had positive coefficients of 1.1 and 3.8, respectively, suggesting that higher age and more authoritarian attitudes were associated with increased investment in SCZ but did not have a similar impact on HV investments.

Furthermore, when considering the feedback conditions, the results show that before feedback, only age (with a coefficient of 0.5) was a significant predictor of investment in SCZ (SCZ Pre) and not in HV (HV Pre). This suggests that in the absence of feedback, age played a role in shaping trust behaviour specifically towards individuals with schizophrenia.

In the post feedback condition, age (with a coefficient of 0.8), authoritarianism (with a coefficient of 2.2), and stigma (with a coefficient of 0.1) were significant predictors of investment in SCZ (SCZ Post) but not in HV (HV Post). This indicates that after receiving feedback, factors like age, authoritarian attitudes, and perceptions of stigma towards mental illness influenced investment decisions specifically towards individuals with schizophrenia. After receiving feedback from the SCZ, people with less stigma invested more when compared to people with more stigma. Additionally, the lack of significant predictors for healthy volunteers suggests that trust behaviour towards them might be influenced by different factors compared to individuals with schizophrenia.

**Independent sample t test comparing low stigma benevolence and high stigma benevolence groups**

*Independent sample t test comparing low stigma benevolence and high stigma benevolence groups on HV and SCZ*

**Table 32**

| Variable | Stigma | N | Mean | S.D | t | Sig |
|---|---|---|---|---|---|---|
| HV | Low stigma | 27 | 70.8 | 33.88 | 1.809 | 0.07 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | High stigma | 22 | 55.6 | 22.11 | | |
| SCZ | Low stigma | 27 | 70.22 | 33.76 | 0.601 | 0.55 |
| | High stigma | 22 | 64.36 | 34.20 | | |

Note HV is investment done on healthy individual and SCZ is investment on individual with schizophrenia

From the above independent sample t test table, it is revealed that there was no statistically significant difference in HV scores between the Low stigma BE group (M = 70.8, SD = 33.88) and the High Stigma BE group (M = 55.6, SD = 33.76).

Similarly, there was no statistically significant difference in SCZ scores between the Low Stigma BE group (M = 70.22, SD = 34.20) and the High Stigma BE group (M = 64.36, SD = 34.20) (t = 0.601, p = 0.55). These findings suggest that stigma levels according to benevolence attitude did not have a significant impact on the HV and SCZ scores.

*Independent sample t test comparing low stigma and high stigma groups according to benevolence on HV pre and SCZ pre*

**Table 33**

| Variable | Stigma | N | Mean | S.D | t | Sig |
|---|---|---|---|---|---|---|
| HV pre | Low stigma | 27 | 37 | 17.52 | 2.117 | 0.04 |
| | High stigma | 22 | 32 | 15.26 | | |
| SCZ pre | Low stigma | 27 | 36.3 | 17.5 | 1.05 | 0.29 |
| | High stigma | 22 | 27.64 | 15.26 | | |

Note HV pre is investment done on healthy individual before feedback condition and SCZ is investment done on individual living with schizophrenia before feedback condition

In the independent samples t test, comparing the mean scores of two groups (low stigma and high stigma group according to benevolence) on the variable HV_Pre, it was found that there is a statistically significant difference between the two groups. The t value is 2.117, and the corresponding p value is 0.040. The mean difference between the two groups is 8.660, indicating that the low stigma group has, on average, invested more on healthy volunteers before feedback condition compared to the high stigma group.

In the case of SCZ pre, there was no statistical significance between the low stigma and high stigma group as the p value 0.29 is below the conventional significance value.

*Independent sample t test comparing low stigma and high stigma groups according to benevolence on HV post and SCZ post*

**Table 34**

| Variable | Stigma | N | Mean | S.D | T | Sig |
|---|---|---|---|---|---|---|
| HV post | Low stigma | 27 | 42.6 | 17.6 | 2.239 | 0.03 |
| | High stigma | 22 | 32.3 | 13.79 | | |
| SCZ post | Low stigma | 27 | 47.1 | 21.1 | 1.78 | 0.08 |
| | High stigma | 22 | 36.55 | 20 | | |

Note HV post is investment done on healthy individual after feedback condition and SCZ is investment done on individual living with schizophrenia after feedback condition

Based on the t test, it was found that there is a statistically significant difference between the two groups' mean scores on HV_Post as the t value is 2.239, and the corresponding p value is 0.030. The mean difference between the two groups is 10.303, indicating that low stigma group according to benevolence has, on average, higher scores on HV_Post compared to the other group.

In the case of SCZ post, the t value was 1.78 and the corresponding P value is 0.08. Thus it can be concluded that there is no statistical significant difference between low stigma benevolence group and high stigma benevolence group as the p value is below the conventional significance value.

*Independent sample t test comparing low stigma and high stigma groups according to benevolence on HV total and SCZ total*

**Table 35**

| Variable | Stigma | N | Mean | S.D | T | Sig |
|---|---|---|---|---|---|---|
| HV total | Low stigma | 27 | 107.1 | 47.38 | 2.075 | 0.04 |
| | High stigma | 22 | 83.27 | 32.79 | | |
| SCZ total | Low stigma | 27 | 107.2 | 49.78 | 0.774 | 0.44 |
| | High stigma | 22 | 96.36 | 48.34 | | |

Note HV total is total investment done on healthy individual and SCZ total is total investment done on individual living with schizophrenia before feedback condition

In the independent samples t test, comparing the mean scores of two groups (low stigma benevolence group and high stigma benevolence group) on the variable HV_Total, it was found that there is statistically significant difference between the two groups. The t value is 2.075, and the corresponding p value is 0.044. This suggests that the difference in the mean scores of the two groups on HV_Total is significant at the conventional significance level ($p < 0.05$). the mean difference is 23.833 indicating low stigma group invested more on HV total than high stigma group.

In the case of SCZ total, there is no statistically significant difference between the two groups as the t value is 0.772, and the corresponding p value is 0.444.

*Independent sample t test comparing low stigma and high stigma groups according to benevolence on pre total and post total*

**Table 36**

| **Variable** | **Stigma** | **N** | **Mean** | **S.D** | **T** | **Sig** |
|---|---|---|---|---|---|---|
| Pre total | Low stigma | 27 | 73.33 | 27.89 | 1.826 | 0.07 |
| | High stigma | 22 | 59.64 | 23.74 | | |
| Post total | Low stigma | 27 | 83.41 | 30.73 | 2.279 | 0.02 |

| | | | |
|---|---|---|---|
| High stigma | 22 | 64.18 | 27.58 |

Note pre total is total investment done before feedback condition and post total is total investment done before feedback condition

In the independent samples t test, comparing the mean scores of two groups (low stigma benevolence group and high stigma benevolence group) on the variable Post_Total, it was found that there is no statistically significant difference between the two groups' mean scores as the t value is 1.826, and the corresponding p value is 0.074. This suggests that the difference in the mean scores of the two groups on Pre_total is not significant at the conventional significance level ($p < 0.05$). However, the p value is close to the significance threshold, indicating that there may be a trend towards significance.

In the case of post total, there is a statistically significant difference between the two groups' mean scores as the t value is 2.279, and the corresponding p value is 0.027. The mean difference between the two groups is 19.226, it indicates that the mean score of the first group (low stigma) is significantly higher than the mean score of the second group (high stigma) on Post_Total.

*Independent sample t test comparing low stigma and high stigma groups according to benevolence on pre total and post total*

**Table 37**

| Variable | Stigma | N | Mean | S.D | T | Sig |
|---|---|---|---|---|---|---|
| Total investment | Low stigma | 27 | 214.37 | 79.49 | 1.62 | 0.11 |
| | High stigma | 22 | 179.64 | 68.06 | | |

Note total investment is total investment done to both HV and SCZ

In the independent samples t test, we are comparing the mean scores of two groups (low stigma benevolence group and high stigma benevolence group) on the variable Total_investment. The t value is 1.621, and the corresponding p value is 0.112. This suggests that the difference in the mean scores of the two groups on Total_investment is not significant at the conventional significance level ($p > 0.05$).

In summary, in the study comparing the low stigma benevolence group and the high stigma benevolence group, it was observed that there were significant differences in variables HV, HV pre, HV post, HV and post feedback total. But no significant differences was found in variables related to SCZ, SCZ pre, SCZ post, pre feedback total and total investment. Interestingly, the low benevolence stigma group invested more in HV compared to the high benevolence stigma group.

This may manifest stigma indirectly as people low in benevolence stigma, indicating good attitude towards mentally ill did invest more consistently on all HV investments that high benevolence stigma individuals but this difference couldn't be seen in the case of SCZ investments consistently. This phenomenon could potentially be attributed to the social desirability bias apparent in participants' responses to the questionnaire. Their underlying implicit attitudes towards individuals with mental illnesses might have influenced their behaviour in the trust game.

**Independent sample t test comparing low stigma social restrictiveness and high stigma social restrictiveness groups**

*Independent sample t test comparing low stigma social restrictiveness and high stigma social restrictiveness groups on HV and SCZ*

**Table 38**

| Variable | Stigma | N | Mean | S.D | T | Sig |
|---|---|---|---|---|---|---|
| SCZ | Low stigma | 6 | 103.33 | 27.89 | 2.991 | 0.004 |
| | High stigma | 43 | 62.60 | 23.74 | | |
| HV | Low stigma | 6 | 70.67 | 30.73 | 0.579 | 0.565 |

| | | | | |
|---|---|---|---|---|
| | High stigma | 43 | 63.07 | 27.58 |

Note HV post is investment done on healthy individual after feedback condition and SCZ is investment done on individual living with schizophrenia after feedback condition

In the above independent samples t test table, the mean scores of two groups ( low stigma and high stigma ) on the variable SCZ are compared it was found that there is a statistically significant difference between the two groups' mean scores on SCZ. As the t value is 2.991, and the corresponding p value is 0.004. The mean difference between the two groups is 40.729, suggesting low stigma group invested more in SCZ.

In case of HV, the t value is 0.579, and the corresponding p value is 0.565. This suggests that the difference in the mean scores of the two groups on HV is not significant at the conventional significance level ($p > 0.05$).

*Independent sample t test comparing low stigma and high stigma groups according to social restrictiveness on HV pre and SCZ pre*

**Table 39**

| **Variable** | **Stigma** | **N** | **Mean** | **S.D** | **T** | **Sig** |
|---|---|---|---|---|---|---|
| SCZ pre | Low stigma | 6 | 48 | 11.314 | 2.165 | 0.03 |
| | | 43 | 32.93 | 16.442 | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | High stigma | | | | | |
| | Low stigma | 6 | 34.67 | 14.895 | | |
| HV pre | | | | | 0.397 | 0.69 |
| | High stigma | 43 | 32.09 | 14.877 | | |

Note HV pre is investment done on healthy individual before feedback condition and SCZ is investment done on individual living with schizophrenia before feedback condition

In the above independent samples t test table, the mean scores of two groups (low stigma and high stigma) on the variable SCZ_Pre are compared. The t value is 2.165, and the corresponding p value is 0.036. This suggests that the difference in the mean scores of the two groups on SCZ_pre is significant at the conventional significance level ($p < 0.05$). The mean difference between the two groups is 15.070, indicating low stigma group invested more on SCZ pre than the other group.

In case of HV pre, there is no statistical difference between the two groups as the p value is above conventional value(0.69).

*Independent sample t test comparing low stigma and high stigma groups according to social restrictiveness on HV post and SCZ post*

**Table 40**

| Variable | Stigma | N | Mean | S.D | T | Sig |
|---|---|---|---|---|---|---|
| SCZ post | Low stigma | 6 | 64 | 11.02 | 4.499 | 0.001 |
| | High stigma | 43 | 39.35 | 20.48 | | |
| HV post | Low stigma | 6 | 44.67 | 15.88 | 1.040 | 0.304 |
| | High stigma | 43 | 37.12 | 16.75 | | |

Note HV post is investment done on healthy individual after feedback condition and SCZ is investment done on individual living with schizophrenia after feedback condition

In the above independent samples t test table, the mean scores of two groups ( low stigma social restrictiveness and high stigma social restrictiveness group) on the variable SCZ post are compared. As the t value is 2.872, and the corresponding p value is 0.006, it can be said that there is a statistically significant difference between the two groups. The mean difference between the two groups is 24.651, indicating low stigma group invested more on SCZ post than high stigma group.

In case of HV_Post, The t value is 1.040, and the corresponding p value is 0.304. This suggests that the difference in the mean scores of the two groups on HV_Post is not significant at the conventional significance level ($p > 0.05$).

*Independent sample t test comparing low stigma social restrictiveness and high stigma social restrictiveness groups according to social restrictiveness on HV total and SCZ total*

**Table 41**

| Variable | Stigma | N | Mean | S.D | T | Sig |
|---|---|---|---|---|---|---|
| SCZ total | Low stigma | 6 | 151.33 | 27.29 | 2.796 | 0.007 |
| | High stigma | 43 | 95.16 | 47.52 | | |
| HV total | Low stigma | 6 | 105.33 | 45.090 | 0.541 | 0.591 |
| | High stigma | 43 | 95.16 | 42.856 | | |

Note HV total is total investment done on healthy individual and SCZ total is total investment done on individual living with schizophrenia before feedback condition

In the above independent samples t test table, the mean scores of two groups (low stigma social restrictiveness and high stigma social restrictiveness group) on the variable SCZ_total are compared. The t value is 2.796, and the corresponding p value is 0.007, suggesting a statistically significant relation between the two groups. The mean difference between the two groups is 55.798, suggesting higher average SCZ total investment by low stigma group compared to high stigma group

In case of HV_Total, the t value is 0.541, and the corresponding p value is 0.591. This suggests that the difference in the mean scores of the two groups on HV_Total is not statistically significant at the conventional significance level ($p > 0.05$).

*Independent sample t test comparing low stigma social restrictiveness and high stigma social restrictiveness groups according to social restrictiveness on pre total and post total*

**Table 42**

| **Variable** | **Stigma** | **N** | **Mean** | **S.D** | **T** | **Sig** |
|---|---|---|---|---|---|---|
| Pre total | Low stigma | 6 | 82.67 | 91.21 | 1.535 | 0.132 |
| | High stigma | 43 | 65.02 | 27.10 | | |
| Post total | Low stigma | 6 | 98.67 | 17.64 | 2.112 | 0.04 |

| | | | |
|---|---|---|---|
| High stigma | 43 | 71.44 | 30.69 |

Note pre total is total investment done before feedback condition and post total is total investment done before feedback condition

In the above independent samples t test table, the mean scores of two groups ( low stigma social restrictiveness and high stigma social restrictiveness) on the variable pre_total are compared, the t value is 1.535, and the corresponding p value is 0.132. This suggests that the difference in the mean scores of the two groups on Pre_Total is not statistically significant at the conventional significance level ($p > 0.05$).

In the case of Post_Total, the t value is 2.112, and the corresponding p value is 0.01. This suggests that the difference in the mean scores of the two groups on Post_Total is statistically significant at the conventional significance level ($p < 0.05$). The mean difference between the two groups is 27.225, indicating low stigma group has higher average post total scores than high stigma group.

*Independent sample t test comparing low stigma social restrictiveness and high stigma social restrictiveness groups on total investment*

*Table 43*

| Variable | Stigma | N | Mean | S.D | T | Sig |
|---|---|---|---|---|---|---|
| Total investment | Low stigma | 6 | 256.6 | 50.74 | 2.062 | 0.04 |
| | High stigma | 43 | 190.7 | 75.65 | | |

Note total investment is the total amount invested in both SCZ and HV in total

In the independent samples t test table, the observed t value is 2.062, and the corresponding p value is 0.045. This suggests that the difference in the mean scores of the two groups on Total_investment is significant at the conventional significance level ($p < 0.05$). The mean difference between the two groups is 65.969, indicating that low stigma group has higher mean investment on total investment than other group.

In summary, upon contrasting the low stigma social restrictiveness group with the high stigma social restrictiveness group, notable differences emerged. There were statistically significant disparities in SCZ, SCZ PRE, SCZ POST, pre total, total investment, and post total between the two groups. However, no significant differences were observed in HV, HV PRE, HV POST, and HV TOTAL. Intriguingly, the low social restrictiveness stigma group exhibited higher investments in SCZ compared to the high stigma group.

This outcome might reflect the impact of participants' varying perceptions and attitudes towards individuals with mental illnesses. The increased investment in SCZ by the low social restrictiveness stigma group could suggest a greater willingness to engage with and support individuals who are perceived as having schizophrenia. This group might harbour more

empathy and less apprehension when interacting with those facing mental health challenges. Conversely, the lack of significant differences in HV investments for both groups could imply a more generalized and consistent pattern of trust behaviour across different stigma levels.

**Independent sample t test comparing low stigma and high stigma groups according to community mental health ideology**

*Independent sample t test comparing low stigma mental health ideology group and high stigma mental health ideology groups on SCZ, SCZ pre, SCZ post, SCZ total, HV, HV pre, HV post, post total and pre total investments*

*Table 44*

| Variable | Stigma | N | Mean | S.D | T | Sig |
|---|---|---|---|---|---|---|
| SCZ | Low stigma | 16 | 58 | 33.178 | 1.366 | 0.178 |
| | High stigma | 32 | 72.13 | 34.040 | | |
| HV | Low stigma | 16 | 67.75 | 26.95 | 0.552 | 0.58 |
| | High stigma | 32 | 62.63 | 31.86 | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| SCZ pre | Low stigma | 16 | 30.75 | 17.93 | 1.175 | 0.24 |
| | High stigma | 32 | 36.75 | 16.04 | | |
| HV pre | Low stigma | 16 | 33 | 12.52 | 0.136 | 0.89 |
| | High stigma | 32 | 32.38 | 16.04 | | |
| SCZ post | Low stigma | 16 | 37 | 20.10 | 1.293 | 0.202 |
| | High stigma | 32 | 45.38 | 21.63 | | |
| HV post | Low stigma | 16 | 38.25 | 18.35 | 0.024 | 0.981 |
| | High stigma | 32 | 38.13 | 16.31 | | |
| SCZ total | Low stigma | 16 | 88.75 | 50.11 | 1.341 | 0.187 |
| | High stigma | 32 | 108.88 | 48.48 | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Low stigma | 16 | 100.75 | 37.47 | | |
| HV total | | | | | 0.432 | 0.668 |
| | High stigma | 32 | 95 | 46.08 | | |
| | Low stigma | 16 | 82.67 | 91.21 | | |
| Pre total | | | | | 0.646 | 0.52 |
| | High stigma | 32 | 65.02 | 27.10 | | |
| | Low stigma | 16 | 82.67 | 91.21 | | |
| Post total | | | | | 0.818 | 0.41 |
| | High stigma | 32 | 65.02 | 27.10 | | |

In the independent samples t test table comparing the mean scores of two groups (high mental health ideology stigma group and low mental health ideology stigma group) on the variable SCZ.; The t value is 1.366, and the corresponding p value is 0.178, indicating no statistical significance between the two groups.

In case of HV, the t value is 0.552, and the corresponding p value is 0.584. This suggests that the difference in the mean scores of the two groups on HV is not statistically significant at the conventional significance level ($p > 0.05$).

In the independent samples t test comparing the mean scores of two groups on the variable HV_Pre, the t value is 0.136, and the corresponding p value is 0.892. This suggests that the difference in the mean scores of the two groups on HV_Pre is not statistically significant at the conventional significance level ($p > 0.05$).

In the case of SCZ post, the t value is 1.293, and the corresponding p value is 0.202. This suggests that the difference in the mean scores of the two groups on SCZ_Post is not statistically significant at the conventional significance level ($p > 0.05$).

For HV_Post, the t value is 0.024, and the corresponding p value is 0.981. This suggests that the difference in the mean scores of the two groups on HV_Post is not statistically significant at the conventional significance level ($p > 0.05$).

In the case of SCZ total, the t value is 1.341, and the corresponding p value is 0.187. This suggests that the difference in the mean scores of the two groups on SCZ_Total is also not statistically significant at the conventional significance level ($p > 0.05$).

For HV_Total, the t value is 0.432, and the corresponding p value is 0.668. This suggests that the difference in the mean scores of the two groups on HV_Total is not statistically significant at the conventional significance level ($p > 0.05$).

For Pre_total, the t value is 0.646, and the corresponding p value is 0.522. This suggests that the difference in the mean scores of the two groups on Pre_total is not statistically significant at the conventional significance level ($p > 0.05$).

For Post total, the t value is 0.818, and the corresponding p value is 0.4. This suggests that the difference in the mean scores of the two groups on Pre_total is not statistically significant at the conventional significance level ($p > 0.05$).

Finally for Total investment, the t value is 0.609, and the corresponding p value is 0.546. This suggests that the difference in the mean scores of the two groups on Total_investment is also not statistically significant at the conventional significance level ($p > 0.05$).

**Independent sample t test comparing low stigma and high stigma groups according to stigma**

*Independent sample t test comparing low stigma and high stigma groups on SCZ and HV investments*

**Table 45**

| Variable | Stigma | N | Mean | S.D | T | Sig |
|---|---|---|---|---|---|---|
| SCZ | Low stigma | 11 | 80 | 33.08 | 1.399 | 0.16 |
| | High stigma | 38 | 64 | 33.49 | | |
| HV | Low stigma | 11 | 77.45 | 34.65 | 1.73 | 0.09 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | High stigma | 38 | 60.11 | 27.67 | | |

In the above independent samples t test table, comparing the mean scores of high stigma groups and low stigma groups on the variable SCZ.

Based on the standard t test, we find that there is no statistically significant difference between the two groups' mean scores on SCZ. The t value is 1.399, and the corresponding p value is 0.168. This suggests that the difference in the mean scores of the two groups on SCZ is not statistically significant at the conventional significance level ($p > 0.05$).

In the case of HV, the t value is 1.730, and the corresponding p value is 0.090. This suggests that the difference in the mean scores of the two groups on HV is also not statistically significant at the conventional significance level ($p > 0.05$).

*Independent sample t test comparing low stigma and high stigma groups on SCZ pre and HV pre investments*

**Table 46**

| **Variable** | **Stigma** | **N** | **Mean** | **S.D** | **T** | **Sig** |
|---|---|---|---|---|---|---|
| SCZ Pre | Low stigma | 11 | 42.5 | 12.933 | 1.806 | 0.07 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | High stigma | 38 | 32.5 | 16.97 | | |
| | Low stigma | 11 | 38.18 | 14.46 | | |
| HV pre | | | | | 1.493 | 0.14 |
| | High stigma | 38 | 30.74 | 14.58 | | |

Note HV pre is investment done on healthy individual before feedback condition and SCZ is investment done on individual living with schizophrenia before feedback condition

In the above independent samples t test table, comparing the mean scores of two groups on the variable SCZ_pre. The t value is 2.099, and the corresponding p value is 0.048. This suggests that the difference in the mean scores of the two groups on SCZ_pre is marginally statistically significant at the conventional significance level ($p < 0.05$).The mean difference between the two groups is 10.019, suggesting second group (low stigma group) invested more on SCZ pre than other group.

In the case of HV_Pre, the t value is 1.493, and the corresponding p value is 0.142. This indicates that the difference in the mean scores of the two groups on HV_Pre is not statistically significant at the conventional significance level ($p < 0.05$).

*Independent sample t test comparing low stigma and high stigma groups on SCZ post and HV post investments*

**Table 47**

| Variable | Stigma | N | Mean | S.D | T | Sig |
|---|---|---|---|---|---|---|
| SCZ post | Low stigma | 11 | 53.4 | 19.86 | 2.040 | 0.04 |
| | High stigma | 38 | 39.16 | 20.63 | | |
| HV post | Low stigma | 11 | 43.64 | 16.63 | 1.272 | 0.21 |
| | High stigma | 38 | 36.42 | 16.55 | | |

Note HV pre is investment done on healthy individual after feedback condition and SCZ is investment done on individual living with schizophrenia after feedback condition

In the above independent samples t test table, comparing the mean scores of two groups on the variable SCZ_Post, the t value is 2.040, and the corresponding p value is 0.047. This indicates that the difference in the mean scores of the two groups on SCZ_Post is statistically significant at the conventional significance level ($p < 0.05$).The mean difference between the two groups is 14.297, indicating low stigma group have higher average SCZ post score than high stigma group.

In the case of HV_Post, the t value is 1.272, and the corresponding p value is 0.210. This indicates that the difference in the mean scores of the two groups on HV_Post is not statistically significant at the conventional significance level ($p > 0.05$).

*Independent sample t test comparing low stigma and high stigma groups on SCZ total and HV total investments*

**Table 48**

| Variable | Stigma | N | Mean | S.D | T | Sig |
|---|---|---|---|---|---|---|
| SCZ total | Low stigma | 11 | 122.5 | 43.97 | 1.577 | 0.12 |
| | High stigma | 38 | 96.5 | 49.28 | | |
| HV total | Low stigma | 11 | 115.6 | 46.45 | 1.727 | 0.09 |
| | High stigma | 38 | 90.8 | 40.61 | | |

Note HV total is total investment done on healthy individual and SCZ total is total investment done on individual living with schizophrenia before feedback condition

In the above independent samples t test table, comparing the mean scores of two groups on the variable SCZ_Total, the t value is 1.577, and the corresponding p value is 0.122. This indicates that the difference in the mean scores of the two groups on SCZ_Total is not statistically significant at the conventional significance level ($p > 0.05$). The mean difference between the two groups is 26.019, indicating that low stigma group on average, invested more on SCZ total than high stigma group.

In the case of HV_Total, the t value is 1.727, and the corresponding p value is 0.091. This indicates that the difference in the mean scores of the two groups on HV_Total is not statistically significant at the conventional significance level ($p > 0.05$).

*Independent sample t test comparing low stigma and high stigma groups on pre total and post total investments*

**Table 49**

| **Variable** | **Stigma** | **N** | **Mean** | **S.D** | **T** | **Sig** |
|---|---|---|---|---|---|---|
| Pre total | Low stigma | 11 | 80.73 | 20.22 | 1.96 | 0.056 |
| | High stigma | 38 | 63.26 | 27.33 | | |
| Post total | Low stigma | 11 | 91.64 | 27.09 | 2.15 | 0.03 |

| | | | | |
|---|---|---|---|---|
| | High stigma | 38 | 69.89 | 30.16 |

Note pre total is total investment done before feedback condition and post total is total investment done before feedback condition

In the independent samples t test table above, the t value is 1.963, and the corresponding p value is 0.056. This indicate that the difference in the mean scores of the two groups on Pre_Total is not statistically significant at the conventional significance level.

In the case of Post_Total, the t value is 2.150, and the corresponding p value is 0.037. This indicates that the difference in the mean scores of the two groups on Post_Total is statistically significant at the conventional significance level ($p < 0.05$).The mean difference between the two groups is 21.742, indicating low stigma group has average higher post total score than high stigma group.

**Table no 70**

*Independent sample t test comparing low stigma and high stigma groups on pre total and post total investments*

*Table 50*

| **Variable** | **Stigma** | **N** | **Mean** | **S.D** | **T** | **Sig** |
|---|---|---|---|---|---|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| Total investment | Low stigma | 11 | 238.18 | 57.5 | 2.018 | 0.04 |
| | High stigma | 38 | 187.37 | 77.3 | | |

Note total investment is total investment done to both HV and SCZ

In the above independent samples t test, comparing the mean scores of two groups on the variable Total_investment, the t value is 2.375, and the corresponding p value is 0.027. The mean difference between the two groups is 50.813, it indicates that the mean score of the low stigma group is significantly higher than the mean score of the high stigma group on the variable Total_investment.

**Table 51**

*General linear model table comparing SCZ and HV investments by taking AU and age as covariates*

| | **Coefficient** | **$\eta^2$** | **F** | **P value** |
|---|---|---|---|---|
| Baseline Investments (SCZ VS HV) | 0.91 | 0.089 | 4.512 | 0.03 |
| Baseline investment age | 0.94 | 0.059 | 2.909 | 0.09 |

| | | | | |
|---|---|---|---|---|
| Baseline investment AU | 0.95 | 0.050 | 2.430 | 0.12 |

The provided table presents the results of General linear model table comparing SCZ and HV investments by taking AU and age as covariates

Baseline Investments (SCZ VS HV): The $\eta^2$ value is 0.089.The coefficient estimate for the Baseline Investments (SCZ VS HV) factor is 0.91. The corresponding F-statistic is 4.512.The p-value of 0.03 suggests that the observed effect is significant at the 0.05 alpha level, implying that the differences in baseline investments between SCZ and HV are likely not due to chance.

Baseline Investment Age Interaction: The $\eta^2$ value is 0.059. The calculated F-statistic is 2.909, suggesting that there may be an interaction effect. However, with a p-value of 0.09, the evidence for this interaction is not strong enough to claim statistical significance.

Baseline Investment AU Interaction: For the interaction between Baseline investment and AU (Authoritarianism), The $\eta^2$ value is 0.050, the coefficient estimate is 0.95. The F-statistic is 2.430, indicating a potential interaction effect. Yet, with a p-value of 0.12, the evidence is not robust enough to establish statistical significance.

In summary, the analysis reveals notable findings in terms of baseline investments and their interactions with Age and AU. The statistically significant effect of Baseline Investments (SCZ VS HV) underscores its role in influencing investment decisions. The interactions with Age and AU exhibit suggestive patterns, although they fall short of achieving statistical significance

based on the given p-values. These results provide valuable insights into the relationships between the examined variables and baseline investment outcomes.

**Table 52**

*General linear model table comparing SCZ pre and HV pre investments by taking AU and age as covariates*

| | **Coefficient** | **$\eta^2$** | **F** | **P value** |
|---|---|---|---|---|
| Pre Investments (SCZ pre VS HV pre) | 0.92 | 0.073 | 3.596 | 0.06 |
| Pre investment age | 0.92 | 0.008 | 0.371 | 0.54 |
| Pre investment AU | 0.91 | 0.084 | 4.219 | 0.04 |

The provided table presents the outcomes of General linear model table comparing SCZ pre and HV pre investments by taking AU and age as covariates

Pre Investments (SCZ pre VS HV pre): The $\eta^2$ value is 0.073. The associated F-statistic is 3.596, and the corresponding p-value is 0.06. Although the p-value does not meet the conventional threshold of 0.05, the result suggests a notable trend that might warrant further investigation.

Pre Investment Age Interaction: The $\eta^2$ value is 0.008. The F-statistic is 0.371, and the p-value is 0.54. These values indicate that the interaction effect does not appear to be statistically significant, and the observed variation could likely occur by chance.

Pre Investment AU Interaction: The $\eta^2$ value is 0.084 and the F-statistic is 4.219. The p-value is 0.04, which suggests a statistically significant interaction effect at the conventional significance level of 0.05. This result implies that the interaction between pre-investment and authoritarianism is likely not due to random variation.

In summary, the analysis indicates interesting findings regarding the pre-investments and their interactions with AU. While the main effect and the interaction with Age exhibit trends that are not statistically significant, the interaction with AU appears to have a meaningful impact on pre-investments. Further exploration of this interaction could provide insights into the dynamics between pre-investment decisions and levels of authoritarianism.

**Table 53**

*General linear model table comparing SCZ post and HV post investments by taking AU and age as covariates*

| | **Coefficient** | **$\eta^2$** | **F** | **P value** |
|---|---|---|---|---|
| Post Investments (SCZ post VS HV post) | 0.95 | 0.049 | 2.380 | 0.13 |

| | | | | | |
|---|---|---|---|---|---|
| Post age | investment | 0.92 | 0.071 | 3.542 | 0.06 |
| Post AU | investment | 0.98 | 0.018 | 0.857 | 0.36 |

The presented table contains the results of General linear model table comparing SCZ post and HV post investments by taking AU and age as covariates.

Post Investments (SCZ post VS HV post): The $\eta^2$ value is 0.049. The associated F-statistic is 2.380, and the corresponding p-value is 0.13. The result suggests that the observed effect is not statistically significant at the conventional significance level of 0.05.

Post Investment  Age Interaction: The $\eta^2$ value is 0.071. The F-statistic is 3.542, and the p-value is 0.06. While the p-value does not reach the 0.05 threshold, it indicates a trend that could be worth exploring further.

Post Investment  AU Interaction: The $\eta^2$ value is 0.018 and the F-statistic is 0.857. The p-value is 0.36, indicating that the observed interaction effect is not statistically significant.

In summary, the analysis provides insights into the relationship between post-investments and their interactions with Age and AU. While the main effect and the interaction with Age display trends that are not statistically significant at the conventional threshold, the interaction with AU does not demonstrate a statistically significant impact. These findings highlight potential

directions for further exploration and underscore the complexity of variables influencing post-investment decisions.

**Table 54**

*General linear model table comparing SCZ total and HV total investments by taking AU and age as covariates*

| | **Coefficient** | **$\eta^2$** | **F** | **P value** |
|---|---|---|---|---|
| Total Investments (SCZ total VS HV total) | 0.90 | 0.093 | 4.697 | 0.03 |
| Total investment age | 0.95 | 0.044 | 2.099 | 0.15 |
| Total investment AU | 0.93 | 0.066 | 3.246 | 0.78 |

The provided table presents the outcomes of General linear model table comparing SCZ total and HV total investments by taking AU and age as covariates.

Total Investments (SCZ total VS HV total): The $\eta^2$ value is 0.093. The associated F-statistic is 4.697, and the corresponding p-value is 0.03. This suggests a statistically significant effect at the 0.05 significance level, indicating that the observed differences in total investments between SCZ and HV are likely not due to chance.

Total Investment  Age Interaction:  The $\eta^2$ value is 0.044.The F-statistic is 2.099, and the p-value is 0.15. The p-value does not meet the conventional threshold of 0.05, suggesting that the interaction effect is not statistically significant.

Total Investment  AU Interaction: The $\eta^2$ value is 0.066 and the F-statistic is 3.246. However, the p-value is notably high at 0.78, indicating that the observed interaction effect is not statistically significant.

In summary, the analysis provides insights into the relationships between total investments and their interactions with Age and AU. The main effect of Total Investments (SCZ total VS HV total) is statistically significant, suggesting its relevance in influencing total investment decisions. While the interactions with Age and AU do not demonstrate statistically significant effects based on the provided p-values, they still offer valuable insights into potential patterns and relationships within the data.

# CHAPTER V

# SUMMARY AND CONCLUSION

A total of 50 participants with a mean age of 31.92 ( SD = 10.9, Range= 21 To 50 years). years were recruited using purposive sampling method from Trivandrum and Kollam districts of Kerala. The study uses a neurocognitive game called trust game or investment game, popularly used in behavioural economics research, designed by Berg et al to examine trust behaviour towards (SCZ). For data collection, along with trust game, the Community Attitude Towards Mentally Ill scale (CAMI), was used. Participants between the age of 18 to 50 years with absence of lifetime axis 1 diagnosis and with minimum education of seven years were included and participants with serious mental illness or who score below 24 on HMSE Hindi Mental Status Examination scale or individuals with intellectual disability disorder, individuals with family history of psychotic disorders in first degree relatives were excluded from the study. The rationale behind this exclusion is the exposure and the subsequent change in attitude and perception towards mentally ill as a result of close contact with the patients. Hindi Mental Status Examination scale (HMSE), risk propensity scale, Kessler Psychological Distress Scale (K 10) and digit symbol substitution test were used to recruit participants asper inclusion exclusion criteria. The data were found to be consistent with a normal distribution based on the results of the Shapiro-Wilk tests, justifying the use of parametric tests for the analyses.

## Summary

The study aimed to examine the level of trust shown by healthy individual towards person living with schizophrenia compared to healthy controls. Objectives were to compare the investment made to people living with schizophrenia (PwSz) and healthy volunteers (Hv), to examine the effect of feedback on the investments made, to compare the effect of feedback on the investment made to people living with schizophrenia (PwSz) and healthy volunteers (Hv)

and to examine the relationship between investment made to people living with schizophrenia and their attitude towards mentally ill

In the baseline condition, while certain factors demonstrated shared influence on SCZ and HV investments, noteworthy differences were evident. Age and authoritarianism displayed significant impact solely on SCZ investments, indicating that these factors might be more influential when considering investments in individuals with mental illness. Notably, Risk Propensity and Trust Propensity exhibited consistent roles in shaping investments across both SCZ and HV contexts. Also GLM results showed statistically significant results between SCZ investments and HV investments ($\eta^2$=0.089*).

Transitioning to the feedback condition, Risk Propensity and Trust Propensity consistently influenced investments before and after feedback for both SCZ and HV. Age, authoritarianism, and stigma emerged as more pertinent factors for SCZ investments, both pre and post feedback. Particularly, age and authoritarian attitudes played a significant role in SCZ investment decisions, while stigma revealed a negative correlation with post-feedback SCZ investments. This suggests that individuals with more positive attitudes towards persons living with schizophrenia invested more after receiving feedback from them.

Stigma's multifaceted nature finds expression through diverse behaviours in the present study. In the context of this study, stigma was explored in relation to investment decisions. The findings highlight intriguing patterns. Individuals exhibiting higher Authoritarianism (AU), which signifies a tendency towards stigma as they view persons with mental illness as inferior to themselves and in need of supervision, were observed to invest more in people living with schizophrenia (SCZ). This could potentially indicate a complex interplay between negative attitudes and investment behaviour. It could be said that in the case of people with high

authoritarianism, the stigma is getting manifested by more investment to individual with schizophrenia.

Conversely, individuals with elevated Social Restrictiveness (SR), another marker of stigma, as they view people with mental illness as a threat to society and thus should be avoided, displayed a contrasting behaviour. They tended to invest less in SCZ, suggesting a guarded approach, potentially rooted in a perception of mental health conditions as societal threats. Hence it can be said that the stigma is getting manifested by a reduction in investment to individual living with schizophrenia in the case with individuals with high social restrictiveness attitude.

Furthermore, the role of Benevolence (BE) in relation to stigma and investment behaviour is noteworthy. Individuals with low BE, indicating a potential presence of stigma as they are characterized by unsympathetic view towards person with mental illness, exhibited a greater investment inclination towards healthy volunteers (HV) in comparison to individuals with higher BE. This intriguing finding suggests that those with more pronounced stigma might be more willing to support HV, possibly due to the perception of HV being "safer" investment choices. However, this difference in investment propensity was not observed in the context of SCZ investments. This intriguing finding could potentially be attributed to the influence of social desirability bias, wherein participants' implicit attitudes towards individuals with mental illnesses could have impacted their trust game behaviour. This may suggest that individuals with low benevolence stigma, who possess positive attitudes, exhibited more consistent investments across all HV scenarios compared to their high benevolence stigma counterparts Thus here, in the case of benevolence attitude, stigma is getting manifested entirely in different manner.

To elaborate, the observed investment patterns underline the intricate dynamics of stigma's influence on trust decisions. The higher investments from individuals with high AU towards SCZ could stem from a combination of negative attitudes and cautious engagement, possibly reflecting uncertainty about the trustworthiness of individuals with mental health conditions. On the other hand, the reduced investments from those with high SR might signify a sense of distance, potentially driven by a perceived societal risk associated with interacting closely with SCZ.

The phenomenon of low BE individuals investing more in HV could be explained by the preference for perceived "safer" interactions. People with low BE might view HV as less likely to pose any risks or uncertainties, leading to increased investment. Conversely, this distinction was not as prominent in SCZ investments, hinting at the complexity of attitudes and beliefs influencing investment behaviour.

In conclusion, this study offers nuanced insights into how different facets of stigma interplay with investment decisions. The findings underscore the need for a comprehensive understanding of stigma's influence on behavioural choices. This knowledge could guide interventions aimed at reducing stigma's impact and fostering more inclusive attitudes and behaviours.

**Major findings and conclusions**

- 76% of the participants exhibited medium stigma and 22% low stigma towards people with mental illness.
- There is significant difference between SCZ investment and HV investment ($\eta^2$=0.089*).

- There is no significant difference between SCZ pre investments and HV pre investments ($\eta^2$=0.075).
- There is no significant difference between SCZ post investments and HV post investments ($\eta^2$=0.049).
- There is significant difference between SCZ total investments and HV total investments ($\eta^2$=0.093*).
- SCZ showed positive correlations with Age (r = 0.35*), AU (r = 0.34*), TP (r = 0.57**), and RP (r = 0.338*), indicating moderate to strong associations.
- HV exhibited significant positive correlations RP (r = 0.325*), and TP (r = 0.62**)
- SCZ pre was significantly correlated with Age (r = 0.325*), CAMI (r = 0.264), AU (r = 0.297*), BE (r = 0.068), SR (r = 0.145), CMHI (r = 0.084), RP (r = 0.303*), and TP (r = 0.55**), indicating meaningful associations between these variables.
- HV pre scores show significant correlations with RP (r = 0.39**), TP (r = 0.63**)
- SCZ post was significantly correlated with Age (r = 0.39**), CAMI (r = 0.344*), AU (r = 0.303*), RP (r = 0.34**), TP (r = 0.62**).
- HV post was significantly correlated with only trust propensity TP (r = 0.47**).
- SCZ, SCZ pre, SCZ post, SCZ total positively correlated with authoritarianism attitude, age, trust propensity and risk propensity
- HV, HV pre, HV post, HV total positively correlated only with trust propensity and risk propensity
- Age, authoritarianism, social restrictiveness significantly predicted SCZ, SCZ pre, SCZ post and SCZ total investments
- Benevolence significantly predicted HV pre, HV post and HV total investments
- Stigma and trust propensity were negatively correlated and Stigma was a significant predictor of trust propensity (r=-0.286**, B= -0.055). Suggesting that individuals with

more stigmatized attitudes towards the mentally ill tend to have lower levels of trust in people.

- Age exhibited a strong negative correlation with community mental health ideology (r= -0.482**) and positive correlations with CAMI (r = 0.043), social restrictiveness (r = 0.184), and investment in SCZ (r = 0.341*).

**Tenability of hypothesis**

**Table 55**

*Tenability of hypothesis*

| SL no | Hypothesis | Tenability |
|---|---|---|
| 1. | There is no significant relationship between the money invested by healthy individuals on people living with schizophrenia compared to healthy volunteers in the trust game | Rejected |
| 2. | There is no significant difference between pre feedback investment made to people living with schizophrenia (PWSz) and healthy volunteers (Hv) | Accepted |
| 3. | There is no significant difference between pre feedback investment made to people living with schizophrenia (PWSz) and healthy volunteers (Hv) | Accepted |
| 4. | There is no significant difference between the effect of trust on the investment made to people living with schizophrenia (PWSz) and healthy volunteers (Hv) | Rejected |

| | | |
|---|---|---|
| | | |
| 5. | There is no significant relationship between the investment made to people living with schizophrenia and the attitude towards mentally ill | Rejected |

**Implications Of The Study**

- Addresses existing research gap: Study address the gap in research related to trust behaviour towards individuals with schizophrenia.
- Anti-Stigma Interventions - The study's findings provide valuable insights into the relationship between stigma and investment decisions. This understanding can inform the development of targeted anti-stigma interventions.
- Enhancing Trust Building: The study sheds light on the complex interplay between stigma and trust. Findings suggests that addressing stigma is crucial for building trust. Strategies aimed at reducing stigma can consequently contribute to fostering trust and more positive interactions between different groups.
- Contribution to Trust Research: The study contributes to the broader field of trust research by exploring the dynamics of trust and stigma in a novel context. As no study has examined the trust behaviour towards PWSCZ, these findings add depth to the understanding of lower trust behaviour exhibited by the individuals living with schizophrenia.
- Guiding Future Research: The study opens avenues for further research in understanding stigma's impact on various decision-making processes. Future research

can explore the broader implications of stigma on behaviours beyond investment decisions, offering a comprehensive view of its pervasive influence on society.

**Implications from a counselling psychology perspective:**

- Tailoring Therapeutic Approaches : The study's findings hold significance for counselling psychologists who work with individuals facing mental health challenges. Understanding the impact of stigma on investment decisions can help therapists tailor their approaches. By addressing the underlying stigma-related biases, therapists can guide clients towards more informed and unbiased decision-making, fostering self-awareness and empowerment
- Addressing Self-Stigma: The study sheds light on how individuals' attitudes towards mental illness influence their investment behaviour. Counselling psychologists can use this insight to address self-stigma in clients. By helping clients recognize and challenge their own stigmatizing beliefs, therapists can support them in making decisions that align with their authentic values rather than societal biases.
- Enhancing Interpersonal Relationships : The study's exploration of trust dynamics has implications for counselling psychologists working with clients in relationships affected by mental health biases. Therapists can guide clients towards understanding and mitigating the impact of stigma on their interactions. This can lead to improved communication, empathy, and trust-building within relationships.
- Supporting Advocacy and Education: Counselling psychologists can use the study's insights to support advocacy efforts. By educating clients, families, and communities about the impact of stigma on decision-making, psychologists can contribute to reducing stigma and promoting more inclusive attitudes towards mental health.
- Ethical Considerations: The study's insights underscore the ethical responsibilities of counselling psychologists. It encourages practitioners to recognize and address their

own biases and stigma-related attitudes to provide unbiased and client-centered support. This can contribute to the overall well-being of clients seeking counselling services.

**Limitations of the study**

- The study's sample size was constrained with a modest count of 50 healthy volunteers (HV), potentially circumscribing the scope for broad generalizations.
- Notably, a disproportionally higher proportion of female participants was evident in the study cohort, warranting caution in the interpretation of findings, which could potentially exhibit a gender-based bias in the outcomes of the current investigation.
- Some of the findings of the study were based on self-reported data and may have been susceptible to response bias

**Suggestions for future research**

- Future investigations could benefit from the inclusion of more expansive sample sizes, enabling a more robust analysis.
- Additionally, potential avenues for research might involve offering participants tangible monetary incentives, thereby enhancing the ecological validity of the study's findings.
- Could encompass cross-cultural studies, allowing for the exploration of cultural variations and their potential influence on the investigated phenomena. Such investigations could provide valuable insights into the interplay between cultural contexts and the observed outcomes.

## References

Ajzen, I. (2011). The theory of planned behaviour: Reactions and reflections. *Psychology & Health*, *26*(9), 1113–1127. https://doi.org/10.1080/08870446.2011.613995

Alarcon, G. M., Lyons, J. B., Christensen, J. C., Klosterman, S. L., Bowers, M. A., Ryan, T. J., Jessup, S. A., & Wynne, K. T. (2017). The effect of propensity to trust and perceptions of trustworthiness on trust behaviours in dyads. *Behaviour Research Methods*, *50*(5), 1906–1920. https://doi.org/10.3758/s13428-017-0959-6

Almeida, R., Trigueiro, M. J., Portugal, P., Sousa, S., Simões-Silva, V., Campos, F., Silva, M. J., & Marques, A. (2023). Mental Health Literacy and Stigma in a municipality in the north of Portugal: a Cross-Sectional Study. *International Journal of Environmental Research and Public Health*, *20*(4), 3318. https://doi.org/10.3390/ijerph20043318

Andreasen, N. C. (1985). Positive vs. Negative Schizophrenia: A Critical Evaluation. *Schizophrenia Bulletin*, *11*(3), 380–389. https://doi.org/10.1093/schbul/11.3.380

Bellucci, G., Chernyak, S., Goodyear, K., Eickhoff, S. B., & Krueger, F. (2016). Neural signatures of trust in reciprocity: A coordinate-based meta-analysis. *Human Brain Mapping*, *38*(3), 1233–1248. https://doi.org/10.1002/hbm.23451

Bentall, R. P., Corcoran, R., Howard, R., Blackwood, N., & Kinderman, P. (2001). Persecutory delusions: a review and theoretical integration. *Clinical Psychology Review*, *21*(8), 1143–1192. https://doi.org/10.1016/s0272-7358(01)00106-4

Berg, J. E., Dickhaut, J., & McCabe, K. (1995). Trust, reciprocity, and social history. *Games and Economic Behaviour*, *10*(1), 122–142. https://doi.org/10.1006/game.1995.1027

Bilder, R. M., Goldman, R., Volavka, J., Czobor, P., Hoptman, M. J., Sheitman, B., Lindenmayer, J. P., Citrome, L., McEvoy, J. P., Kunz, M., Chakos, M., Cooper, T. B., Horowitz, T. L., & Lieberman, J. A. (2002). Neurocognitive effects of clozapine, olanzapine, risperidone, and haloperidol in patients with chronic schizophrenia or schizoaffective disorder. *American Journal of Psychiatry*, *159*(6), 1018–1028. https://doi.org/10.1176/appi.ajp.159.6.1018

Blankertz, L. (2001). Cognitive components of self esteem for individuals with severe mental illness. *American Journal of Orthopsychiatry*, *71*(4), 457–465. https://doi.org/10.1037/0002-9432.71.4.457

Boti, N., Hussen, S., Ayele, G., Mersha, A., Gebeyehu, S., Kassa, M., Feleke, T., & Temesgen, G. (2020). Community Perception and Attitude Towards People living with schizophrenia Among Residents of Arba Minch Zuria District, Arba Minch Health and Demographic Surveillance Sites System (AM-HDSS), Ethiopia: Cross-Section Study *Risk Management and Healthcare Policy*. https://doi.org/10.2147/rmhp.s241713

Brown, R., & Gaertner, S. L. (2002). Blackwell Handbook of Social Psychology: Intergroup Processes. In *Blackwell Publishing Ltd eBooks*. https://doi.org/10.1111/b.9781405106542.2002.x

Camerer, C. F., & Fehr, E. (2004). Measuring social norms and preferences Using Experimental Games: A guide for social Scientists. In *Oxford University Press eBooks* (pp. 55–95). https://doi.org/10.1093/0199262055.003.0003

Cannon, T. D., Glahn, D. C., Kim, J., Van Erp, T. G., Karlsgodt, K. H., Cohen, M. S., Nuechterlein, K. H., Bava, S., & Shirinyan, D. (2005). Dorsolateral Prefrontal Cortex Activity During Maintenance and Manipulation of Information in Working Memory in Patients With Schizophrenia. *Archives of General Psychiatry*, *62*(10), 1071. https://doi.org/10.1001/archpsyc.62.10.1071

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rüsch, N., Brown, J., & Thornicroft, G. (2014). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine*, *45*(1), 11–27. https://doi.org/10.1017/s0033291714000129

Coleman, P. T., Deutsch, M., & Marcus, E. (2000). *The Handbook of Conflict Resolution: Theory and Practice*. http://ci.nii.ac.jp/ncid/BB16286195

Colquitt, J. A., Scott, B. A., & LePine, J. A. (2007). Trust, trustworthiness, and trust propensity: A meta-analytic test of their unique relationships with risk taking and job performance. *Journal of Applied Psychology*, *92*(4), 909–927. https://doi.org/10.1037/0021-9010.92.4.909

Corrigan, P. W. (2004). How stigma interferes with mental health care. *American Psychologist*, *59*(7), 614–625. https://doi.org/10.1037/0003-066x.59.7.614

Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care. *Psychological Science in the Public Interest*, *15*(2), 37–70. https://doi.org/10.1177/1529100614531398

Corrigan, P. W., Powell, K. J., & Rüsch, N. (2012). How does stigma affect work in people with serious mental illnesses? *Psychiatric Rehabilitation Journal*, *35*(5), 381–384. https://doi.org/10.1037/h0094497

Corrigan, P. W., Watson, A. C., & Ottati, V. (2003). From Whence Comes Mental Illness Stigma? *International Journal of Social Psychiatry*, *49*(2), 142–157. https://doi.org/10.1177/0020764003049002007

Dunning, D., Fetchenhauer, D., & Schlösser, T. (2019). Why People trust: Solved puzzles and open mysteries. *Current Directions in Psychological Science*, *28*(4), 366–371. https://doi.org/10.1177/0963721419838255

Erikson, E. H. (1950). *Childhood and society*. http://ci.nii.ac.jp/ncid/BA23759278

Fabrega, H. (1991). Psychiatric stigma in non-Western societies. *Comprehensive Psychiatry*, *32*(6), 534–551. https://doi.org/10.1016/0010-440x(91)90033-9

Fett, A., Shergill, S. S., Joyce, D. W., Riedl, A., Strobel, M., Gromann, P. M., & Krabbendam, L. (2012). To trust or not to trust: the dynamics of social interaction in psychosis. *Brain*, *135*(3), 976–984. https://doi.org/10.1093/brain/awr359

Ganguli, M., Ratcliff, G., Chandra, V., Sharma, S. D., Gilby, J. E., Pandav, R., Belle, S. H., Ryan, C. M., Baker, C. E., Seaberg, E. C., & DeKosky, S. T. (1995). A hindi version of the MMSE: The development of a cognitive screening instrument for a largely illiterate rural elderly population in india. *International Journal of Geriatric Psychiatry*, *10*(5), 367–377. https://doi.org/10.1002/gps.930100505

Garety, P., & Freeman, D. (1999). Cognitive approaches to delusions: A critical review of theories and evidence. *British Journal of Clinical Psychology*, *38*(2), 113–154. https://doi.org/10.1348/014466599162700

Gary, F. A. (2005). STIGMA: BARRIER TO MENTAL HEALTH CARE AMONG ETHNIC MINORITIES. *Issues in Mental Health Nursing*, *26*(10), 979–999. https://doi.org/10.1080/01612840500280638

Gueorguieva, R., & Krystal, J. H. (2004). Move over ANOVA: progress in analyzing repeated-measures data and its reflection. *Archives of General Psychiatry*, *61*(3), 310. https://doi.org/10.1001/archpsyc.61.3.310

Hartini, N., Fardana, N. A., Ariana, A. D., & Wardana, N. D. (2018). Stigma toward people with mental health problems in Indonesia. *Psychology Research and Behaviour Management*, *Volume 11*, 535–541. https://doi.org/10.2147/prbm.s175251

Holmes, J. G. (1981). The Exchange Process in Close Relationships. *Springer eBooks*, 261–284. https://doi.org/10.1007/978-1-4899-0429-4_12

Johnson, N. D., & Mislin, A. (2011). Trust games: A meta-analysis. *Journal of Economic Psychology*, *32*(5), 865–889. https://doi.org/10.1016/j.joep.2011.05.007

Jones, S. L., & Shah, P. (2016). Diagnosing the locus of trust: A temporal perspective for trustor, trustee, and dyadic influences on perceived trustworthiness. *Journal of Applied Psychology*, *101*(3), 392–414. https://doi.org/10.1037/apl0000041

Keefe, R. S., Goldberg, T. E., Harvey, P. D., Gold, J. M., Poe, M. P., & Coughenour, L. (2004). The Brief Assessment of Cognition in Schizophrenia: reliability, sensitivity, and comparison with a standard neurocognitive battery. *Schizophrenia Research*, *68*(2–3), 283–297. https://doi.org/10.1016/j.schres.2003.09.011

Kohler, C. G., & Brennan, A. R. (2004). Recognition of facial emotions in schizophrenia. *Current Opinion in Psychiatry*, *17*(2), 81–86. https://doi.org/10.1097/00001504-200403000-00003

Koschorke, M., Padmavati, R., Kumar, S., Cohen, A., Weiss, H. A., Chatterjee, S., Pereira, J., Naik, S., Selander, J., Dabholkar, H., Balaji, M., Chavan, A., Varghese, M., Rangaswamy, T., Thornicroft, G., & Patel, V. (2014). Experiences of stigma and discrimination of people living with schizophrenia in India. *Social Science & Medicine*, *123*, 149–159. https://doi.org/10.1016/j.socscimed.2014.10.035

Yao, J., Zhang, Z. X., & Brett, J. M. (2016). Understanding trust development in negotiations: An interdependent approach. *Journal of Organizational Behavior*, *38*(5), 712–729. https://doi.org/10.1002/job.2160

Mayer, R. C., Davis, J. H., & Schoorman, F. D. (1995). An Integrative Model Of Organizational Trust. *Academy of Management Review*, *20*(3), 709–734. https://doi.org/10.5465/amr.1995.9508080335

Mayer, R. C., Davis, J. H., & Schoorman, F. D. (1995b). An Integrative Model Of Organizational Trust. *Academy of Management Review*, *20*(3), 709–734. https://doi.org/10.5465/amr.1995.9508080335

McKnight, D. H., Cummings, L. L., & Chervany, N. L. (1998). Initial trust formation in new organizational relationships. *Academy of Management Review*, *23*(3), 473–490. https://doi.org/10.5465/amr.1998.926622

Meertens, R. M., & Lion, R. (2008). Measuring an individual's tendency to take risks: the risk propensity scale. *Journal of Applied Social Psychology*, *38*(6), 1506–1520. https://doi.org/10.1111/j.1559-1816.2008.00357.x

Mojtabai, R. (2007). Americans' attitudes toward mental Health Treatment Seeking: 1990–2003. *Psychiatric Services*, *58*(5), 642–651. https://doi.org/10.1176/ps.2007.58.5.642

Murray, S., Holmes, J. G., & Collins, N. L. (2006). Optimizing assurance: The risk regulation system in relationships. *Psychological Bulletin, 132*(5), 641–666. https://doi.org/10.1037/0033-2909.132.5.641

Ng, C. H. (1997). The stigma of mental illness in Asian cultures. *Australian and New Zealand Journal of Psychiatry, 31*(3), 382–390. https://doi.org/10.3109/00048679709073848

Ociskova, M., Prasko, J., Kamaradova, D., Grambal, A., & Sigmundova, Z. (2015). Individual correlates of self-stigma in patients with anxiety disorders with and without comorbidities. *Neuropsychiatric Disease and Treatment*, 1767. https://doi.org/10.2147/ndt.s87737

Overton, S. L., & Medina, S. (2008). The stigma of mental illness. *Journal of Counselling and Development, 86*(2), 143–151. https://doi.org/10.1002/j.1556-6678.2008.tb00491.x

Pandav, R., Fillenbaum, G. G., Ratcliff, G., Dodge, H. H., & Ganguli, M. (2002). Sensitivity and Specificity of cognitive and functional screening instruments for dementia: The Indo-U.S. Dementia Epidemiology Study. *Journal of the American Geriatrics Society, 50*(3), 554–561. https://doi.org/10.1046/j.1532-5415.2002.50126.x

Paul, E Tory Higgins, & Kruglanski, A. W. (2022). *Social psychology : handbook of basic principles.* The Guilford Press.

Penn, D. L., Judge, A., Jamieson, P., Garczynski, J., Hennessy, M., & Romer, D. (2005).

Penn, D. L., Sanna, L. J., & Roberts, D. L. (2007). Social cognition in schizophrenia: An Overview. *Schizophrenia Bulletin*, *34*(3), 408–411. https://doi.org/10.1093/schbul/sbn014

Phelan, J. C., Lucas, J. W., Ridgeway, C. L., & Taylor, C. (2014). Stigma, status, and population health. *Social Science & Medicine*, *103*, 15–23. https://doi.org/10.1016/j.socscimed.2013.10.004

Pillutla, M. M., Malhotra, D., & Murnighan, J. K. (2003). Attributions of trust and the calculus of reciprocity. *Journal of Experimental Social Psychology*, *39*(5), 448–455. https://doi.org/10.1016/s0022-1031(03)00015-5

Rangaswamy, T., & Srinivasan, T. N. (2000). How stigmatising is schizophrenia in India? *International Journal of Social Psychiatry*, *46*(2), 135–141. https://doi.org/10.1177/002076400004600206

Rempel, J. K., Holmes, J. G., & Zanna, M. P. (1985). *Trust in close relationships.* (Vol. 49). American Psychological Association. https://doi.org/10.1037/0022-3514.49.1.95

Robson, S. E., Repetto, L., Gountouna, V., & Nicodemus, K. K. (2019). A review of neuroeconomic gameplay in psychiatric disorders. *Molecular Psychiatry*, *25*(1), 67–81. https://doi.org/10.1038/s41380-019-0405-5

Rotter, J. B. (1971). Generalized expectancies for interpersonal trust. *American Psychologist*, *26*(5), 443–452. https://doi.org/10.1037/h0031464

Schomerus, G., & Angermeyer, M. C. (2008). Stigma and its impact on help-seeking for mental disorders: what do we know? *Epidemiologia E Psichiatria Sociale*, *17*(1), 31–37. https://doi.org/10.1017/s1121189x00002669

Serva, M. A., Fuller, M. A., & Mayer, R. C. (2005). The reciprocal nature of trust: a longitudinal study of interacting teams. *Journal of Organizational Behaviour*, *26*(6), 625–648. https://doi.org/10.1002/job.331

Sharp, M., Fear, N. T., Rona, R., Wessely, S., Greenberg, N., Jones, N., & Goodwin, L. (2015). Stigma as a barrier to seeking health care among military personnel with mental health problems. *Epidemiologic Reviews*, *37*(1), 144–162. https://doi.org/10.1093/epirev/mxu012

Simpson, J. A., & Belsky, J. (2008). Attachment theory within a modern evolutionary framework. In *Guilford Press eBooks*

Stangl, A., Earnshaw, V. A., Logie, C. H., Van Brakel, W. H., Simbayi, L. C., Barre, I., & Dovidio, J. F. (2019). The Health Stigma and Discrimination Framework: a global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas. *BMC Medicine*, *17*(1). https://doi.org/10.1186/s12916-019-1271-3

Taylor, S. M., & Dear, M. (1981). Scaling community attitudes toward the mentally ill. *Schizophrenia Bulletin*, *7*(2), 225–240. https://doi.org/10.1093/schbul/7.2.225

Thaler, R. H., & Johnson, E. J. (1990). Gambling with the House Money and Trying to Break Even: The Effects of Prior Outcomes on Risky Choice. *Management Science*, *36*(6), 643–660. https://doi.org/10.1287/mnsc.36.6.643

Thornicroft, G. (2008). Stigma and discrimination limit access to mental health care. *Epidemiologia E Psichiatria Sociale*, *17*(1), 14–19. https://doi.org/10.1017/s1121189x00002621

Tiwari, S. K., Tripathi, R. K., & Kumar, A. (2008). Applicability of the Mini-mental State Examination (MMSE) and the Hindi Mental State Examination (HMSE) to the urban elderly in India: a pilot study. *International Psychogeriatrics*, *21*(01), 123. https://doi.org/10.1017/s1041610208007916

Treating and Preventing adolescent Mental Health Disorders: What we know and what we Don't know. A Research Agenda for improving the Mental health of our youth. (2006c). *American Journal of Psychiatry*, *163*(4), 753. https://doi.org/10.1176/appi.ajp.163.4.753

Tsolaki, M., Iakovidou, V., Navrozidou, H., Aminta, M., Pantazi, T., & Kazis, A. (2000). Hindi Mental State Examination (HMSE) as a screening test for illiterate demented patients. *International Journal of Geriatric Psychiatry*, *15*(7), 662–664. https://doi.org/10.1002/1099-1166(200007)15:7

Tzieropoulos, H. (2013). The Trust Game in neuroscience: A short review. *Social Neuroscience*, *8*(5), 407–416. https://doi.org/10.1080/17470919.2013.832375

Venkatesh, B. T., Andrews, T., Mayya, S. S., Singh, M. M., & Parsekar, S. S. (2015). Perception of stigma toward mental illness in South India. *Journal of Family Medicine and Primary Care*, *4*(3), 449. https://doi.org/10.4103/2249-4863.161352

Wedekind, C., & Milinski, M. (1996). Human cooperation in the simultaneous and the alternating Prisoner's Dilemma: Pavlov versus Generous Tit-for-Tat. *Proceedings of the National Academy of Sciences of the United States of America*, *93*(7), 2686–2689. https://doi.org/10.1073/pnas.93.7.2686

Weigold, M. F., & Schlenker, B. R. (1991). Accountability and risk taking. *Personality and Social Psychology Bulletin*, *17*(1), 25–29. https://doi.org/10.1177/0146167291171004

Wischniewski, J., Windmann, S., Juckel, G., & Brüne, M. (2009). Rules of social exchange: Game theory, individual differences and psychopathology. *Neuroscience & Biobehavioural Reviews*, *33*(3), 305–313. https://doi.org/10.1016/j.neubiorev.2008.09.008

Yanos, P. T., DeLuca, J. S., Roe, D., & Lysaker, P. H. (2020). The impact of illness identity on recovery from severe mental illness: A review of the evidence. *Psychiatry Research-neuroimaging*, *288*, 112950. https://doi.org/10.1016/j.psychres.2020.112950

Yanos, P. T., Lysaker, P. H., & Roe, D. (2010). Internalized stigma as a barrier to improvement in vocational functioning among people living with schizophrenia-spectrum disorders. *Psychiatry Research-neuroimaging*, *178*(1), 211–213. https://doi.org/10.1016/j.psychres.2010.01.003

# Appendix

**INFORMED CONSENT FORM FOR HEALTHY VOLUNTEERS**

**Overview**

My name is …… and I am a postgraduate student pursuing M.Sc. counselling Psychology in …….. I have undertaken a research study entitled "examination of societal perception and trust behaviour towards patients with schizophrenia "under the guidance of Dr. ……., Assistant professor, Department of Counselling Psychology, ……...

You are invited to participate in this research study which will examine the societal perception and trust behaviour towards people with schizophrenia. To decide whether you wish to participate in this study, you should know about the risks and benefits involved to make an informed judgment. This sheet gives you detailed information about the study and you should feel free to ask any other questions that you may have. Once you understand the study procedures you may choose to participate by signing the attached form.

**Study procedures**

Preliminary screening: In the screening session, I will explain all the details of the study and answer any questions you may have. At this meeting, you will be asked questions to confirm that you meet the requirements to take part in the study.

Investment game : This session will take approximately 180 minutes. This is a computerized game in which you are endowed with 12 units of money, anonymously paired and assigned to either the role of sender or receiver. If needed you may take breaks in between and may be done over 2 days.

**Risks and Inconveniences**

There are no major risks involved in the study however there are minor risks and inconveniences which are listed below. The study altogether may take up to 3 hours and you may feel tired or uncomfortable. If needed you may take breaks in between.

Safety

To ensure your safety the following precautions will be taken:

i) All adequate precautions will be taken and procedures will be explained to you.
ii) Support will be available to you for the entire duration of the study

**Benefits**

By participating in this study, you will not have any direct benefit. Your participation will contribute to scientific knowledge.

**Confidentiality**

If any reports or publications result from this study, no information will be revealed that will permit readers to identify you. If you would like to know the results of the study or your individual results on any of the measures, I would be happy to reveal them to you after the data has been completely analysed. All the information obtained in this study will be kept confidential to the extent permitted by the law.

**Voluntary Participation**

You are free to choose not to participate. If you choose to participate you are free to withdraw from the study at any time without giving any reason.

**Discontinuing the study**

If the study investigator determines that it is not in your best interest to continue in the study, your involvement may be discontinued any time.

SOCIETAL PERCEPTION AND TRUST BEHAVIOUR

**Questions**

Please feel free to ask about any terms you don't understand

**Undertaking by the investigator***:*

Your consent to participate in the above study by Ms. …….. is sought. You have the right to refuse consent or withdraw the same during any part of the study without giving any reason. The information you provide will be stored and maintained safely and confidentially. The data will be used solely for research purposes . Results will be published as dissertation and may be presented in academic conferences or published in scientific journals, without identifying the participants. If you have any doubts about the study, please feel free to clarify the same. Even during the study, you are free to contact any of the investigators during working hours (9 a.m. – 4.30 p.m., Monday-Saturday) for clarifications if you so desire.

Sign

Name

SOCIO DEMOGRAPHIC PROFORMA

| | |
|---|---|
| AGE | |
| GENDER | |
| MARITAL STATUS | |
| RESIDENCE<br>(urban / rural) | |
| RELIGION | |
| EDUCATION QUALIFICATION | |
| ANNUAL INCOME | |
| EMPLOYMENT STATUS | |
| Is anyone in your immediate family suffering from psychotic disorders? | |

The following questions ask about how you have been feeling during the **past 30 days**. For each question, please circle the number that best describes how often you had this feeling.

| **Q1. During that month, how often did you feel …** | **All of the time** | **Most of the time** | **Some of the time** | **A little of the time** | **None of the time** |
|---|---|---|---|---|---|
| **a.** … tired out for no good reason? | **1** | **2** | **3** | **4** | **5** |
| **b.** …nervous? | **1** | **2** | **3** | **4** | **5** |
| **c.** …so nervous that nothing could calm you down? | **1** | **2** | **3** | **4** | **5** |
| **d.** …hopeless? | **1** | **2** | **3** | **4** | **5** |
| **e.** …restless or fidgety? | **1** | **2** | **3** | **4** | **5** |
| **f.** …so restless that you could not sit still? | **1** | **2** | **3** | **4** | **5** |
| **g.** …depressed? | **1** | **2** | **3** | **4** | **5** |
| **h.** …so depressed that nothing could cheer you up? | **1** | **2** | **3** | **4** | **5** |
| **i.** …that everything was an effort? | **1** | **2** | **3** | **4** | **5** |
| **j.** …worthless? | **1** | **2** | **3** | **4** | **5** |

**Q2.** The last ten questions asked about feelings that might have occurred during the past 30 days. Taking them altogether, did these feelings occur More often in the past 30 days than is usual for you, about the same as usual, or less often than usual? (If you never have any of these feelings, circle response option "4.")

| **More often than usual** | | | **About the same as usual** | **Less often than usual** | | |
|---|---|---|---|---|---|---|
| **A lot** | **Some** | **A little** | | **A little** | **Some** | **A lot** |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** |

The next few questions are about how these feelings may have affected you in the past 30 days. You need not answer these questions if you answered "None of the time" to **all** of the ten questions about your feelings.

**Q3.** During the past 30 days, how many days out of 30 were you totally unable to work or carry out your normal activities because of these feelings?

_____ **(Number of days)**

**Digit symbol substitution test**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---|---|---|---|---|---|---|---|---|
| — | ⊥ | ] | ∟ | ∪ | 0 | ^ | × | = |

| 2 | 1 | 3 | 7 | 2 | 4 | 8 | 1 | 5 | 4 | 2 | 1 | 3 | 2 | 1 | 4 | 2 | 3 | 5 | 2 | 3 | 1 | 4 | 6 | 3 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | | | | | | | |

| 1 | 5 | 4 | 2 | 7 | 6 | 3 | 5 | 7 | 2 | 8 | 5 | 4 | 6 | 3 | 7 | 2 | 8 | 1 | 9 | 5 | 8 | 4 | 7 | 3 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | | | | | | | |

| 6 | 2 | 5 | 1 | 9 | 2 | 8 | 3 | 7 | 4 | 6 | 5 | 9 | 4 | 8 | 3 | 7 | 2 | 6 | 1 | 5 | 4 | 6 | 3 | 7 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | | | | | | | |

| 9 | 2 | 8 | 1 | 7 | 9 | 4 | 6 | 8 | 5 | 9 | 7 | 1 | 8 | 5 | 2 | 9 | 4 | 8 | 6 | 3 | 7 | 9 | 8 | 6 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | | | | | | | |

**Q4.** **Not counting the days you reported in response to Q3**, how many days in the past 30 were you able to do only half or less of what you would normally have been able to do, because of these feelings?

_____ **(Number of days)**

**Q5.** During the past 30 days, how many times did you see a doctor or other health professional about these feelings?

_____ **(Number of times)**

| | | All of the time | Most of the time | Some of the time | A little of the time | None of the time |
|---|---|---|---|---|---|---|
| **Q6.** | During the past 30 days, how often have physical health problems been the main cause of these feelings? | **1** | **2** | **3** | **4** | **5** |

*Risk Propensity Scale*

Please indicate the extent to which you agree or disagree with the following statement by putting a circle around the option you prefer. Please do not think too long before answering; usually your first inclination is also the best one.

1. Safety first.

totally disagree 1 2 3 4 5 6 7 8 9 totally agree

2. I do not take risks with my health.

totally disagree 1 2 3 4 5 6 7 8 9 totally agree

3. I prefer to avoid risks.

totally disagree 1 2 3 4 5 6 7 8 9 totally agree

4. I take risks regularly.

totally disagree 1 2 3 4 5 6 7 8 9 totally agree

5. I really dislike not knowing what is going to happen.

totally disagree 1 2 3 4 5 6 7 8 9 totally agree

6. I usually view risks as a challenge.

totally disagree 1 2 3 4 5 6 7 8 9 totally agree

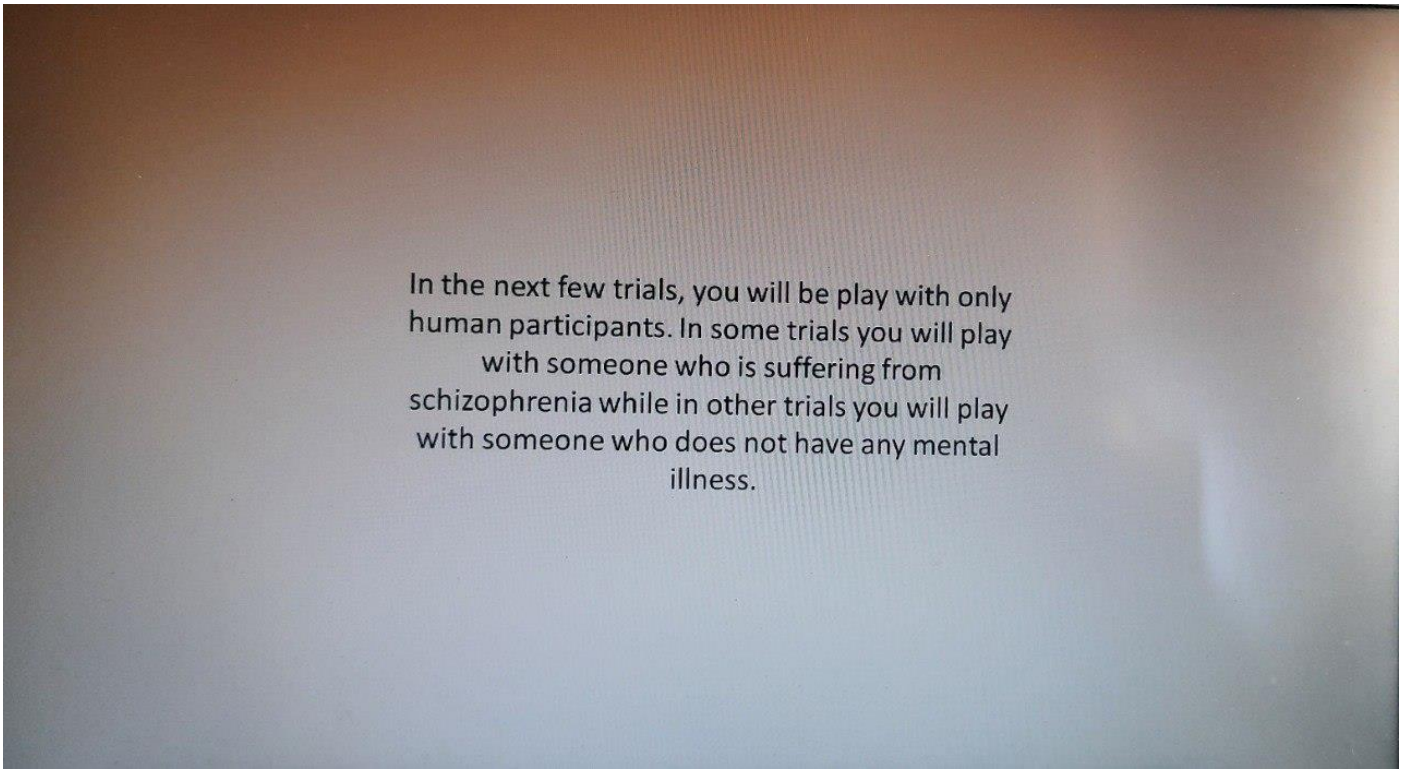
7. I view myself as a . . .

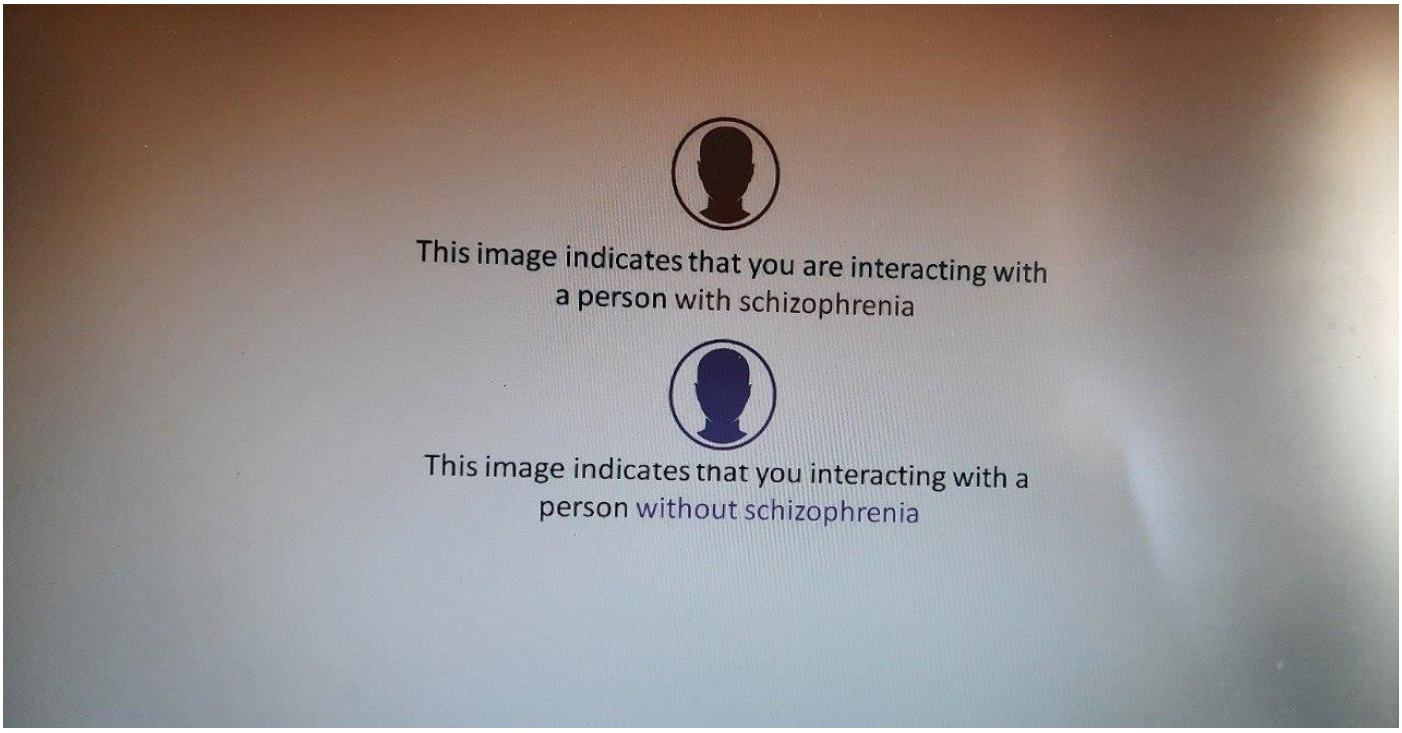
risk avoider 1 2 3 4 5 6 7 8 9 risk seeker

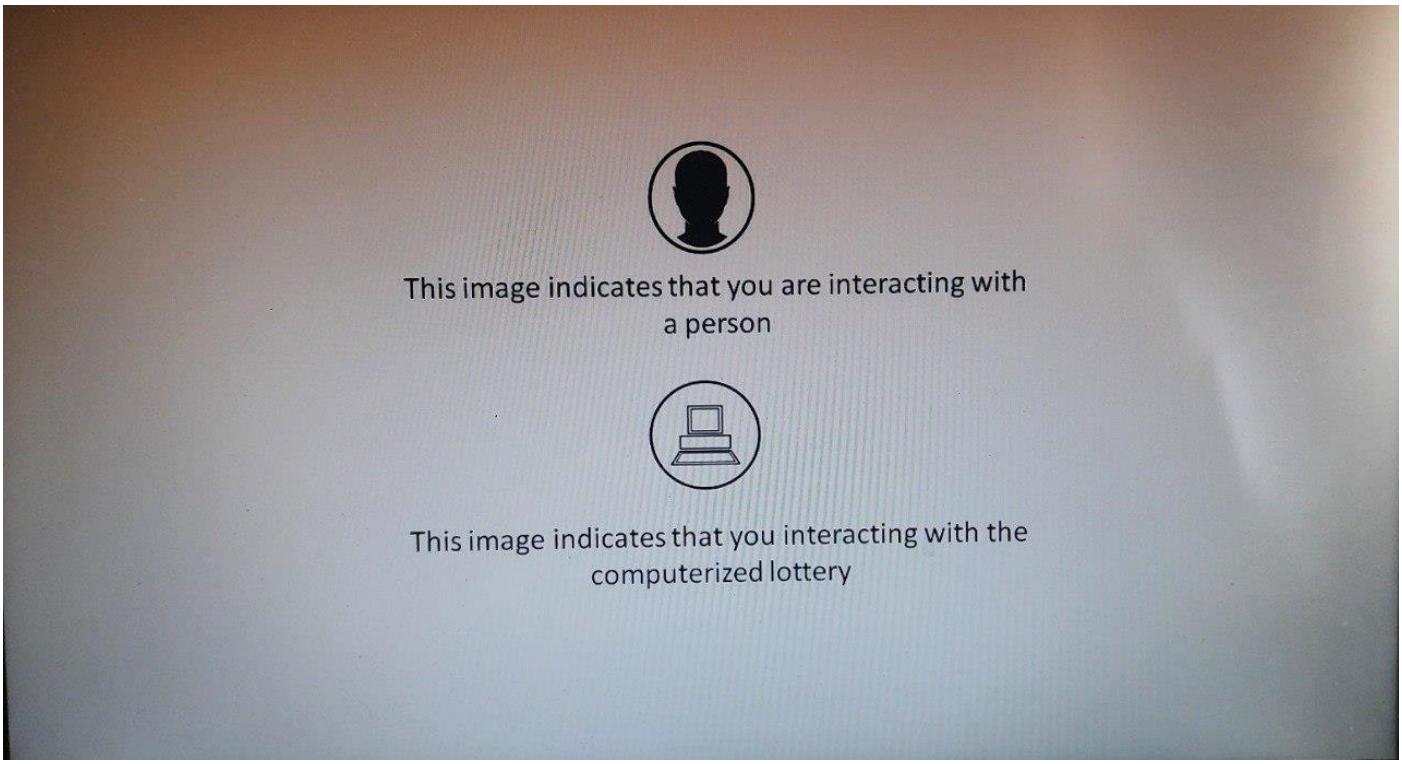
CAMI 12

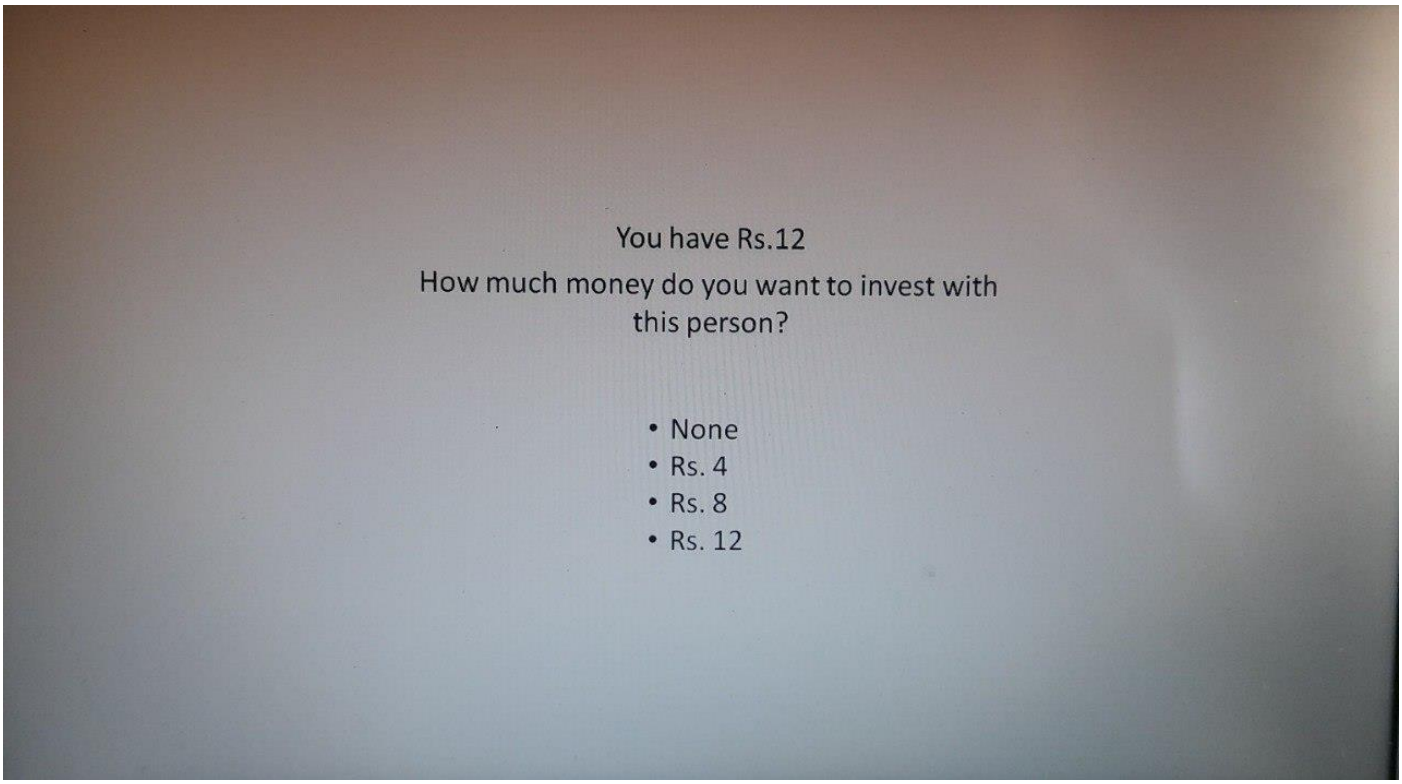
| | Agree strongly | Agree slightly | Neither agree nor disagree | Disagree slightly | Disagree strongly |
|---|---|---|---|---|---|
| One of the main causes of mental illness is a lack of self-discipline and will-power | 1 | 2 | 3 | 4 | 5 |
| There is something about people with mental illness that makes it easy to tell them from normal people | 1 | 2 | 3 | 4 | 5 |
| We need to adopt a far more tolerant attitude toward people with mental illness in our society | 1 | 2 | 3 | 4 | 5 |
| People with mental illness don't deserve our sympathy | 1 | 2 | 3 | 4 | 5 |
| I would not want to live next door to someone who has been mentally ill | 1 | 2 | 3 | 4 | 5 |
| It is frightening to think of people with mental problems living in residential neighborhoods | 1 | 2 | 3 | 4 | 5 |
| Mental illness is an illness like any other | 1 | 2 | 3 | 4 | 5 |
| Virtually anyone can become mentally ill | 1 | 2 | 3 | 4 | 5 |
| The best therapy for many people with mental illness is to be part of a normal community | 1 | 2 | 3 | 4 | 5 |
| People with mental health problems are far less of a danger than most people suppose | 1 | 2 | 3 | 4 | 5 |
| People with mental health problems should not be given any responsibility | 1 | 2 | 3 | 4 | 5 |
| Most women who were once patients in a mental hospital can be trusted as babysitters | 1 | 2 | 3 | 4 | 5 |

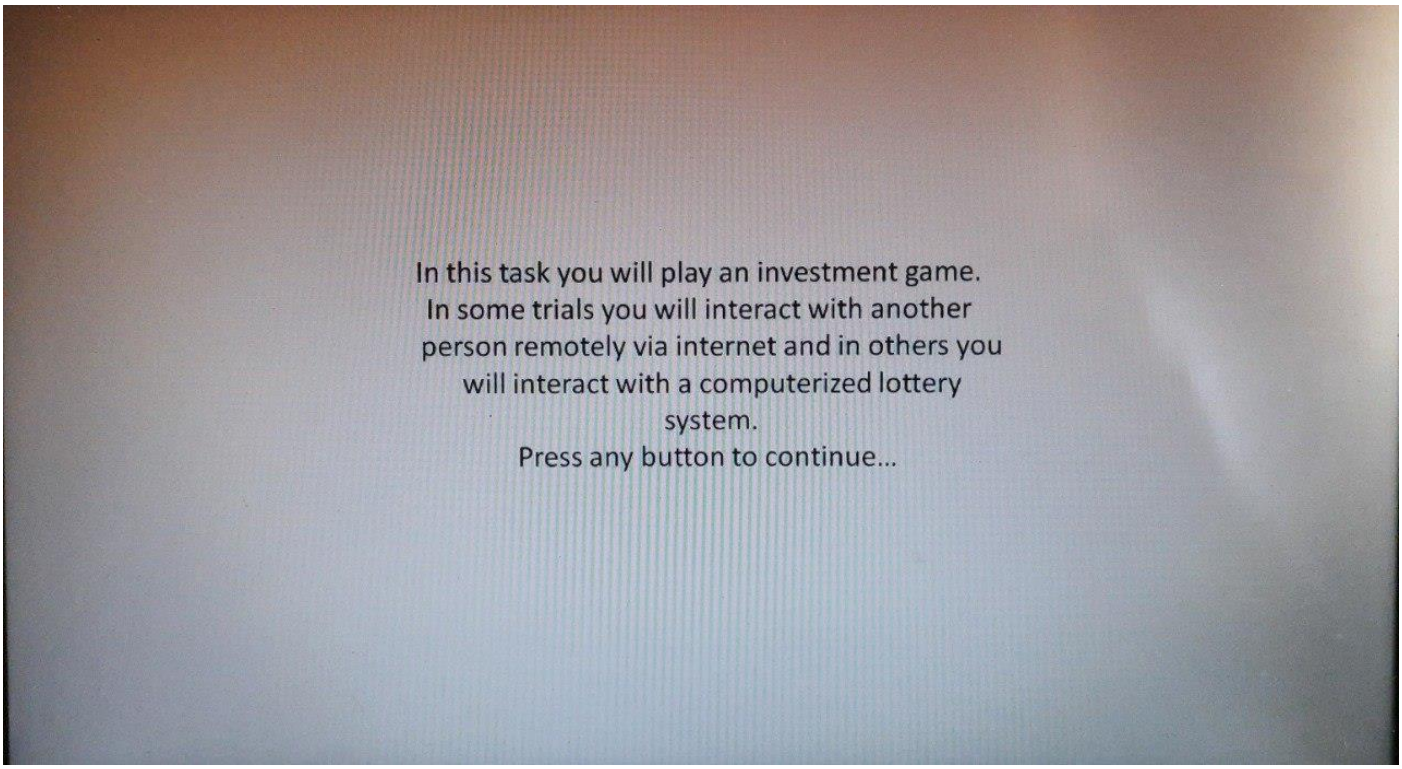
**Trust game**

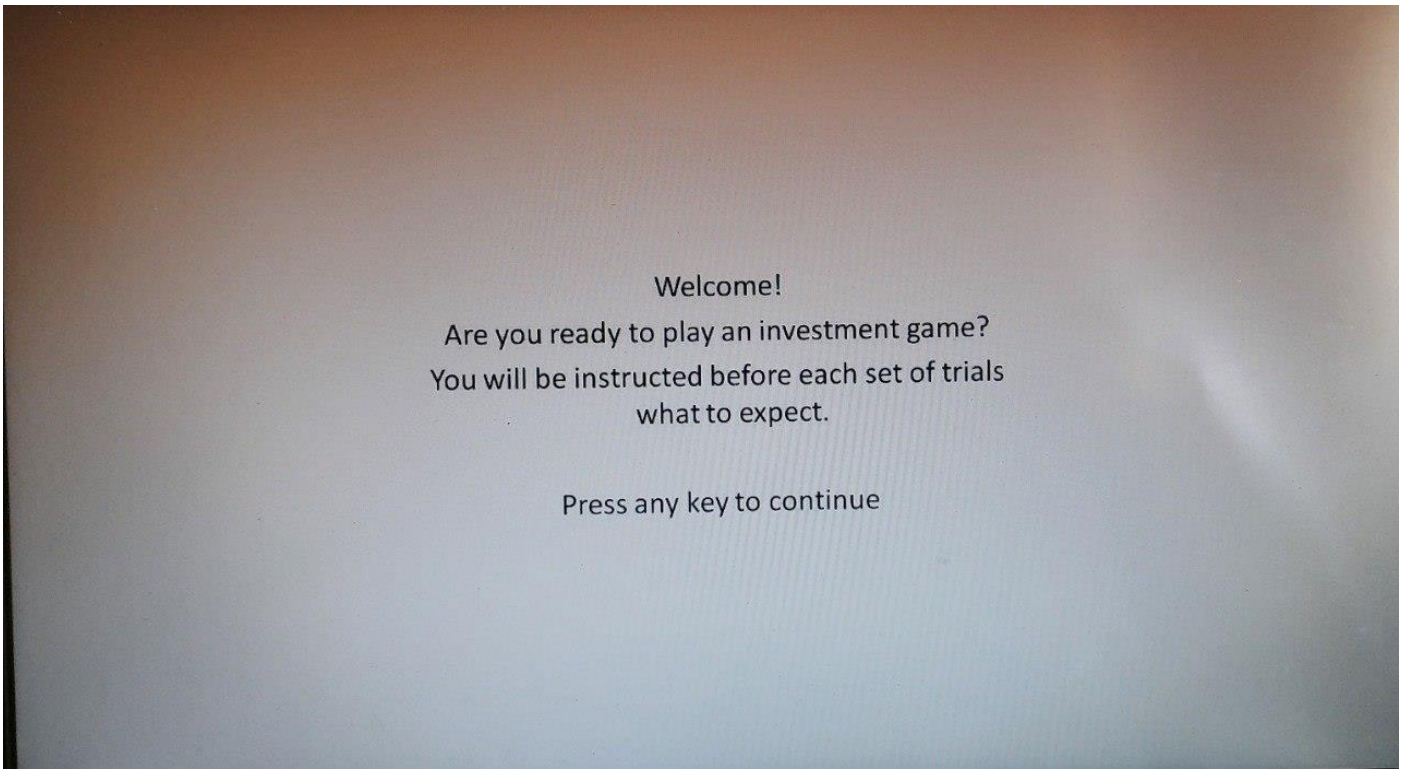

In the next few trials, you will be play with only human participants. In some trials you will play with someone who is suffering from schizophrenia while in other trials you will play with someone who does not have any mental illness.


This image indicates that you are interacting with a person with schizophrenia
This image indicates that you interacting with a person without schizophrenia


This image indicates that you are interacting with a person
This image indicates that you interacting with the computerized lottery


You have Rs.12
How much money do you want to invest with this person?
• None
• Rs. 4
• Rs. 8
• Rs. 12


In this task you will play an investment game.
In some trials you will interact with another person remotely via internet and in others you will interact with a computerized lottery system.
Press any button to continue...


Welcome!
Are you ready to play an investment game?
You will be instructed before each set of trials what to expect.
Press any key to continue

## Hindi Mental Status Examination (HMSE)

| Question | Score (max) |
|---|---|
| Is it morning or afternoon or evening? | (1) |
| What day of the week is it today? | (1) |
| What date is it today? | (1) |
| Which month is it today? | (1) |
| What season of the year is this? | (1) |
| Under which post office does your village come? | (1) |
| Which district does your village fall under? | (1) |
| Which village are you from? | (1) |
| Which block OR Which numbered area is this? | (1) |
| Which place is this? | (1) |
| I went to Delhi and brought three things-mango, chair and coin. What the three things? | (3) |
| Days of the week starting from Sunday | (5) |
| Days of the week backwards | |
| What are the three things, which I told brought back from Delhi? | (3) |
| Identify wrist watch and pen | (2) |
| Repeat the phrase "NEITHER THIS NOR THAT" | (1) |
| Imitate the examiner (Close your eyes for 2 secs) | (1) |
| Take the paper in your right hand, then with both hand fold it once an the paper back to me | (3) |
| Say a sentence about your house | |
| Copy drawing | (3) |
| Total s | (31) |