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# The Role of Contact and Emotional Intelligence in the Attitudes of General Population Towards Individuals Living With Mental Illness

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## ABSTRACT

Mental illness stigma is still a widespread phenomenon with damaging psychological and social consequences. This study is of relevance to the design of appropriate psychiatric services which reinforce the social integration of individuals living with mental illness. It investigates the relationship between contact, emotional intelligence (EI) and attitudes of the general population towards people with mental illness. This study utilized a random sampling method to collect data from 183 participants. Measures included the EI Scale for assessing EI, the level of contact (LOC) Report to examine the LOC with mental illness, and the Attitudes towards Mental Illness Scale to evaluate attitudes towards mental illness. Each of these instruments has been validated in previous research. Data analysis involved Pearson's correlation analysis, multiple linear regression, and mediation analysis to explore the relationships between variables. EI and particularly the abilities of use of emotion and other's emotional appraisal were associated with more positive attitudes towards mental illness. conversely, lower levels of contact were associated with higher levels of social care, indicating a complicated relationship between contact and attitudes. The findings highlight that a deeper understanding of the association between contact with individuals living with mental illness and attitudes towards them is needed, focusing on potential mechanisms that might modify this association. Additionally, a focal point that is underlined in this research is the important role of EI in affecting attitudes as it seems to offer promising directions in planning educational programs and stigma reduction interventions.

## 1 | Introduction

There is a growing research attention in recent years on people's attitudes and beliefs about mental illness. This work is of relevance to the design and planning of appropriate psychiatric services and training programs which are still required to help reduce stigma and reinforce the social integration of people living with mental illness. The importance of reducing the levels of social stigma and discrimination related to mental illness has been increasingly recognized, especially after the first major report of the World Health Organisation on mental health in 2001 (WHO 2001). This report recommended that the public should be educated, and awareness campaigns should be planned because social stigma has adverse outcomes and affects negatively, not only the individuals living with mental illness, but also their families, their treatment, and society as a whole (Feldman and Crandall 2007). Mental illness social stigma consists of negative attitudes and emotions of the general population toward individuals with mental illness as well as prejudices, stereotypes, and discriminatory behaviors (King et al. 2007).

Despite the changes in the National Health Systems worldwide, due to the psychiatric reform and the continuous efforts to reduce stigma surrounding mental illness, negative attitudes have persisted, or even worsened, in the last few decades (Casados 2017). According to Saridi et al. (2017), negative attitudes towards people living with mental illness persist worldwide among both trained health professionals as well as the general population. The first studies that investigated attitudes towards people with mental disease were conducted in the United States in the 1950s (Cumming and Cumming 1957). Most of these studies demonstrated that negative attitudes towards mental disorders and their sufferers are widespread (Angermeyer and Dietrich 2006). More recently, these findings are supported by Abolfotouh et al. (2019) in Saudi Arabia and the systematic reviews of Gaiha et al. (2020) in India and Parcesepe and Cabassa (2013) in the United States. In Europe, Hellström, Gren Voldby and Eplov (2023) found that there were negative attitudes towards people with mental health problems in the Nordic countries. The same findings were supported in Germany by Angermeyer and Schomerus (2017), Zamorano et al. (2023) and González Sanguino et al. (2023) in Spain.

In Greece, there is not much work conducted in this field. The studies conducted by Mouzas, Angelopoulos and Liakos (2008), Arvaniti et al. (2009), Economou et al. (2020), and Koutra, Mavroeides and Triliva (2022) supported that Greek mental health professionals and the general population preferred to socially distance from people with mental disorders and had negative attitudes towards them. However, most of these studies concerned the attitudes of mental health professionals showing that mental health professionals had stereotypical and negative opinions regarding perception of psychiatric patients.

According to the only systematic review in Greece by Tzouvara, Papadopoulos and Randhawa (2016), the existence of mental illness stigma within the Greek culture on a large scale and the need for further research in this field was highlighted. Despite the importance of reducing mental health stigma in Greece, as in all other countries, the studies conducted in this area are scarce and especially those examining the attitudes of the general population. This study is an attempt to contribute to this research field by examining the role of two factors that may influence the attitudes and beliefs of the general population towards mental illness. One of these factors is the level of contact (LOC) with individuals living with mental illness which describes varying degrees of intimacy of contact with people living with mental disorders and the other is the degree of emotional intelligence (EI) of the general population. More intimate relations mean higher LOC with people living with mental illness.

## 2 | Contact and Attitudes

Social psychological research has demonstrated that contact can increase understanding of stigmatized individuals and may lead to less negative attitudes towards the stigmatized groups (Pettigrew and Tropp 2011). According to Thornicroft et al. (2016), contact with people with mental illness and training are the most effective tools to reduce stigma. This is consistent with the recent findings of Manzanera et al. (2018) and Eiroa-Orosa, Lomascolo and Tosas-Fernández (2021). However, there are other studies that support those high levels of contact with people living with mental illness, actually encourage a desire for greater social distance and certain types of social contact increased negative attitudes toward mental illness (Eisenberg, Downs, and Golberstein 2012).

More recently, Corrigan and Nieweglowski (2019) examined the relationship between familiarity and stigma in 26 peer-reviewed studies and found that 19 studies supported a negative linear relationship between familiarity and stigma. Familiarity has been identified as knowledge of and experience of mental illness (Holmes et al. 1999). However, Corrigan and Nieweglowski (2019) reported that there were five studies with significant relationships in the opposite direction: high familiarity was positively correlated with negative attitudes (Batastini, Bolanos, and Morgan 2014). Some other studies found no relationship between familiarity and attitudes (Pattyn, Verhaeghe, and Bracke 2013). It is possible that people's familiarity with the disability makes them focus on the difficulties associated with the illness rather than the person as a whole, but it does seem that studies on the impact of familiarity on the attitudes toward people living with mental illness are contradictory.

In Greece, there are not many recent studies that examined the impact of contact on attitudes towards people living with mental illness. Antoniadis, Assimakopoulos and Koukoulis (2019) examined the attitudes of Greek students towards people with mental disorders and found that students who had previous contact with persons living with mental illness tended to have more favorable attitudes towards them. However, this was not supported by the studies of Logdanidou, Malliopoulou and Grorgaka (2018) and Nikolaou and Petkari (2022) in Cyprus who found that contact with mentally ill people was not associated with attitudes.

Therefore, the findings of research conducted in Greece in this area are contradictory and there have not been any recent in-depth studies that have examined the role of contact on attitudes of the general population towards people living with mental illness. The current research attempts to address this gap in the literature.

## 3 | The Role of EI

Another factor that may also play an important role in the attitudes towards people living with mental illness is the ability to process and manage information about one's own and others' emotion (OEA), a construct known as EI (Mayer and Salovey 1997). An important aspect of EI, as Goleman (2005) noted, is self-awareness because it provides a foundation for individuals to manage their own emotions and enables them to be more aware of OEA and also increases their ability to manage interactions with others (Goleman 2005). Since greater EI means greater ability to understand and respond to OEA, this provides a basis for exploring the relationship between EI and attitudes towards members of other groups.

There are two main models regarding the conceptual approach and measurement of EI. The first one conceptualizes EI as a

set of cognitive-emotional abilities (Mayer, Roberts, and Barsade 2008) and uses performance measures, such as the Mayer, Salovey & Caruso Emotional Intelligence Test (Mayer et al. 2003). These tests measure the ability of people to solve problems related to emotion. The second one conceptualizes EI within a more general umbrella of individual, self-perceived emotionality, and emotion efficacy (Petrides et al. 2016). It refers to more general social-emotional models that focus on individual differences in the organization and expression of emotions and uses self-reported measures, such as the Wong and Law Emotional Intelligence Scale (WLEIS) (Wong and Law 2002).

EI facilitates relationships with oneself, with others, and with one's environment (Guerrero-Barona et al. 2019). Although there is a great amount of literature demonstrating the importance of EI in interpersonal relations (Brackett, Rivers, and Salovey 2011; Lopes et al. 2010; Mayer, Roberts, and Barsade 2008), there is hardly any research investigating the association between EI and attitudes toward other groups (Makwana et al. 2021). In addition, although there are some studies in this field within the Greek culture (Tzouvara and Papadopoulos 2014) there is not even one, to the best of our knowledge, examining the relationship between EI and attitudes towards mentally ill people. More research is required to deepen our understanding on these phenomena.

Therefore, although the mental healthcare system in Greece has been undergoing reforms for the past two decades and services have moved away from institutional care towards community-based mental health care (Christodoulou et al. 2012), there are not many recent in-depth studies examining the role of contact and EI in reducing social stigma towards people with mental health problems. Building from these insights, the present study was conducted. Participants' attitudes towards people living with mental illness were assessed using the OMI Scale (Cohen and Struening 1962), a measure that has been used in several studies about attitudes. The LCR (Holmes et al. 1999) was used to assess the LOC of the respondents with people with mental illness in an everyday life context and the EI was assessed via WLEIS (Wong and Law 2002).

## 4 | Aim of the Study

This study was conducted in Greece and it aims to (a) test whether LOC with people living with mental illness and attitudes towards them are related and more specifically which factors of the OMI scale are related to attitudes, (b) provide clarity on the relationship between EI and attitudes toward mental illness by examining which factors of EI are related to the factors of the OMI scale and (c) test whether there is a mediating effect of the factors of EI in the relationship between contact and the factors of OMI scale.

According to the contact theory (Allport 1954), it was assumed that contact with mentally ill people would be related to attitudes. In addition, EI which consists of abilities such as management of uncomfortable emotions and better understanding and responding to OEA (Goleman 2005), it was assumed to be also related to the factors of the OMI scale. More specifically, it was expected that higher levels of contact and EI would predict more positive attitudes towards individuals living with mental illness and that the factors of EI would have a mediating effect in the relationship between contact and the factors of the OMI scale.

## 5 | Materials and Methods

### 5.1 | Participants

The study used a random sample of 183 participants selected from a larger pool of individuals who had expressed interest in participating in the study through online platforms and social networks, as well as outreach through universities and community organizations in Greece. The aim of this random selection was to obtain a sample that better reflected a cross-section of the Greek population and to increase the diversity of attitudes and levels of familiarity with mental illness within the sample group.

The inclusion criteria to participate in this study were to be Greek residents over 18 years of age and have sufficient knowledge of the Greek language to understand and answer the research questions. Exclusion criteria included those who were under 18 years of age, were not Greek residents, and were unable to give informed consent to participate in the study due to language barriers or cognitive impairments.

The demographic variables that were examined were gender, and age. The sample consisted of 41 men (22.4%) and 142 women (77.6%). Most of them were in the age group of 24-28 years (77.6%). Most of them were in the age group of 24-28 years (77.6%). The study also examined the educational level and the marital status of the participants. Educational attainment varied, with 13.7% having completed secondary education, 41.0% currently enrolled in university, 35.5% holding a graduate degree and 9.8% holding a postgraduate or doctoral degree. In terms of marital status, 53.0% were single, 41.0% were married and 6.0% were divorced.

### 5.2 | Procedure

After selection, subjects were sent an invitation by an e-mail to participate in the study and were informed about the aims of the study. Participation was voluntary and anonymous. They were then directed to an online platform with questionnaires and informed consent was firstly requested. Contact information of the research team was also given in case there were any questions.

After consenting, participants completed a short demographic data form to facilitate detailed analysis of the findings and three measures related to attitudes toward people living with mental illness, LOC with mental illness, and EI. The average time to complete the questionnaires was 10–15 min. After the data was collected a statistical analysis was conducted.

## 5.3 | Measures

### 5.3.1 | Opinions About Mental Illness

Participants' attitudes towards people living with mental illness were assessed using the Opinions about Mental Illness (OMI) Scale (Cohen and Struening 1962), a measure that has been used in several previous studies. In the present study, the Greek version of the OMI Scale was used (Madianos et al. 2012; Madianos and Economou 1999) as it was standardized for the Greek population. The original scale of Cohen and Struening (1962) consisted of 70 items and yielded five factors, Authoritarianism, Benevolence, Mental Hygiene Ideology, Social Restrictiveness and Interpersonal Etiology. The Greek Version of OMI scale comprises 51 statements and the ratings to each statement were made on a 6-point Likert-type scale ranging from 1 (Strongly Agree) to 6 (Strongly Disagree). Factor analysis of the Greek version of OMI scale revealed five factors, social restriction (SRE), social discrimination (SDI), social care (SCA), social integration (SIN) and etiology (ETI). Although the scale of Cohen and Struening yielded Authoritarianism as one factor, the factor analysis applied to the Greek general population identified SDI instead of Authoritarianism due to different sample characteristics (Madianos et al. 2005). The score for each factor was obtained by subtracting the sum of the scores of each item from a constant number according to the instructions of Madianos et al. (1999). Higher scores mean stronger agreement of the respondent with the attitude that the factor expresses. The reliability coefficient alphas for the five scales of the OMI scale exceeded the minimum of 0.5 and therefore it could be considered a reliable measure of attitudes towards people living with mental illness for the Greek population (Madianos et al. 1999).

### 5.3.2 | Level of Contact Report (LCR)

The LCR is a measure that assesses the LOC of the respondents with mental illness (LOC) and was developed by Holmes et al. (1999). It lists 12 situations of varying degrees of intimacy of contact with people living with mental illness. These situations ranged from the least intimacy "I have never observed a person with mental illness" to high intimacy "I have a serious mental illness." The respondent is asked to check all the statements that he or she has ever experienced. The checked statement that ranks highest in the order of familiarity scale determines the respondent's score on this scale (range of scores 1–12). The higher the score the more intimate the contact situation which means higher LOC with people living with mental illness. The reliability and validity of the measure have been supported by Corrigan and Penn (1999). The report was translated in Greek by Arvaniti et al. (2009).

### 5.3.3 | The Wong Law Emotional Intelligence Scale (WLEIS)

EI was assessed via WLEIS (Wong and Law 2002). The scale was translated in Greek by Kafetsios and Zampetakis (2008) and was used in other studies in Greek population (e.g., Kafetsios, Nezlek, and Vassiou 2011, 2014; Vasiou et al. 2024). It is a self-report scale and includes 16 items. It is based on the four ability dimensions described in the domain of EI: (1) Self-Emotion Appraisal (SEA; e.g., "I have a good sense of why I have certain feelings"), (2) Appraisal of Others' Emotion (AOE; e.g., "I always know my friends' emotion from their behavior"), (3) Use of Emotion (UOE; e.g., "I would always encourage myself to try the best"), (4) Regulation of Emotion (ROE; e.g., "I am able to control my temper and handle difficulties rationally"). Coefficient alphas for the four subscales were 0.83, 0.77, 0.79, and 0.83 for the SEA, AOE, UOE, and ROE, respectively.

## 5.4 | Statistical Analysis

Data analysis was conducted using the Jamovi 2.3.17 statistic software (Şahin & Aybek, 2019). All variables were examined for accuracy of data entry, missing values, and the assumptions of the statistical analyses that were to be carried out, confirming that there were no missing data in the data set. The first stage of the analysis involved examining the descriptive statistics for each variable and the creation of subscales. Next, we conducted Pearson's correlation analysis to identify any significant relationships between the subscales. A multiple linear regression and a mediation analysis were conducted too.

## 5.5 | Ethical Considerations

The research followed strict ethical guidelines to ensure that the dignity, rights, and welfare of all participants were protected. Approval to conduct this study was granted by the Ethics Committee of Mamatsio General Hospital of Kozani (reference number: 88/2023), underlining our commitment to ethical research practices. Participants were fully informed of the aims, methods, and potential impact of the study through detailed information sheets to ensure that informed consent was obtained in a way that respected their autonomy and decision-making. This consent process was facilitated digitally, with participants confirming their understanding and agreement through an online consent mechanism, in line with the principles of the Declaration of Helsinki. To protect the anonymity of participants, no personal identifiers were collected at any stage of the research, thereby maintaining confidentiality and minimizing any potential risk of harm. The study was designed to allow participants the freedom to withdraw at any time.

# 6 | Results

Descriptive statistics of the LCR can be seen in Table 1 below.

Frequencies and percentages of each item of the LCR can be seen in Table 2.

In assessing the relationships between the factors of the OMI, and the aspects of EI, significant correlations were found. There was a moderate negative correlation between SDI and AOE, $r = -0.46$, $p < 0.001$, and a strong negative correlation between SDI and UOE, $r = -0.67$, $p < 0.001$. A weak negative correlation was also found between SDI and ROE, $r = -0.18$, $p = 0.008$.

Social Restriction (SRE) showed a medium negative correlation with AOE, $r = -0.30$, $p < 0.001$, and a moderate negative correlation with UOE, $r = -0.47$, $p < 0.001$. SCA was weakly negatively correlated with level of contact (LOC), $r = -0.15$, $p = 0.024$, SEA, $r = -0.18$, $p = 0.007$, and ROE, $r = -0.13$, $p = 0.046$. Social Integration (SIN) was found to have a small negative correlation with LOC, $r = -0.24$, $p < 0.001$, and a small negative correlation with AOE, $r = -0.26$, $p < 0.001$. Finally, Etiology (ETI) had a moderate negative correlation with AOE, $r = -0.45$, $p < 0.001$, and a moderate negative correlation with UOE, $r = -0.41$, $p < 0.001$ (Table 3).

As it can be seen in Table 4, a multiple linear regression was run to predict SDI from a set of predictors selected based on their theoretical relevance and empirical evidence from preliminary analyses. Specifically, LOC, SEA, AOEA, UOE, and ROE were included due to their demonstrated correlations with SDI, as established by the significant findings between the factors of the Opinions about Mental Illness Scale (OMI) and the various aspects of EI. These preliminary correlations informed the selection of variables, with a moderate to strong negative correlation observed for UOE and OEA, and a weak negative correlation for ROE, guiding their inclusion in the model to explore their predictive power on SDI. A significant regression equation was found [$F(5, 177) = 34.50$, $p < 0.001$], with an $R^2$ of 0.49. The results showed that UOE significantly predicted SDI, $\beta = -0.58$, SE = 0.25, $t(177) = -9.51$, $p < 0.001$. In addition, Appraisal of OEA was a significant predictor of SDI, $\beta = -0.17$, SE = 0.25, $t(177) = -2.72$, $p = 0.007$. However, LOC, $\beta = 0.08$, SE = 0.35, $t(177) = 1.44$, $p = 0.153$, SEA, $\beta = 0.02$, SE = 0.23, $t(177) = 0.23$, $p = 0.818$, and ROE, $\beta = -0.11$, SE =

**TABLE 1** | Descriptive statistics of the level of contact report.

| Descriptive Statistics | Values |
|---|---|
| *N* | 183 |
| Mean | 7.27 |
| Median | 8.00 |
| Standard deviation | 3.00 |
| Minimum | 1 |
| Maximum | 12 |

**TABLE 2** | Frequencies and percentages of items of the level of contact report.

| Contact items | Frequency | % of total |
|---|---|---|
| 1) Never observed a person with a mental illness. | 7 | 3.2% |
| 2) Observed, in passing, a person with mental illness. | 10 | 5.2% |
| 3) Watched movie about mental illness. | 15 | 8.0% |
| 4) Watched television documentary about mental illness. | 10 | 5.2% |
| 5) Observed person with mental illness frequently. | 15 | 8.0% |
| 6) Worked with a person with mental illness | 10 | 5.2% |
| 7) Job includes services for persons with mental illness. | 22 | 12.1% |
| 8) Provides services to persons with mental illness. | 14 | 7.5% |
| 9) Family friend has mental illness. | 22 | 12.6% |
| 10) Relative has mental illness. | 42 | 24.0% |
| 11) Lives with a person who has mental illness. | 12 | 6.7% |
| 12) Has a serious mental illness. | 4 | 2.3% |

**TABLE 3** | Descriptive statistics and correlations of the subscales.

| | LOC | SEA | OEA | UOE | ROE | SDI | SRE | SCA | SIN | M | SD |
|---|---|---|---|---|---|---|---|---|---|---|---|
| LOC | — | | | | | | | | | 7.27 | 3.00 |
| SEA | 0.01 | — | | | | | | | | 22.12 | 3.6 |
| OEA | −0.03 | 0.10 | — | | | | | | | 12.17 | 2.99 |
| UOE | −0.05 | 0.06 | 0.48* | — | | | | | | 12.68 | 3.01 |
| ROE | −0.05 | 0.59* | 0.11 | 0.09 | — | | | | | 19.47 | 3.98 |
| SDI | 0.12 | −0.10 | −0.46* | −0.67* | −0.18*** | — | | | | 30.16 | 12.36 |
| SRE | 0.06 | 0.02 | −0.3* | −0.47* | −0.07 | 0.73* | — | | | 42.7 | 8.59 |
| SCA | −0.15*** | −0.18*** | −0.07* | 0.10 | −0.13 | −0.05 | −0.26* | — | | −2.58 | 4.4 |
| SIN | −0.24** | −0.05 | −0.26* | 0.02 | 0.10 | −0.31* | −0.32* | 0.32* | — | 9.57 | 5.15 |
| ETI | −0.02 | −0.11 | −0.45* | −0.41* | −0.10 | 0.46* | 0.32* | 0.09 | −0.06 | 13.29 | 4.51 |

*$p < 0.001$; **$p < 0.01$; ***$p < 0.05$.

**TABLE 4** | Model coefficients for social discrimination index.

| | | | 95% CI | | | | | 95% CI | |
|---|---|---|---|---|---|---|---|---|---|
| **Predictor** | **Est.** | **SE** | **LL** | **UL** | ***t*** | ***p*** | **Std. Est.** | **LL** | **UL** |
| Intercept | 73.09 | 5.18 | 62.86 | 83.32 | 14.10 | < 0.001 | | | |
| LOC | 0.51 | 0.35 | −0.19 | 1.21 | 1.44 | 0.153 | 0.08 | −0.03 | 0.18 |
| SEA | 0.05 | 0.23 | −0.40 | 0.50 | 0.23 | 0.818 | 0.02 | −0.12 | 0.15 |
| OEA | −0.69 | 0.25 | −1.18 | −0.19 | −2.72 | 0.007 | −0.17 | −0.29 | −0.05 |
| UOE | −2.38 | 0.25 | −2.88 | −1.89 | −9.51 | < 0.001 | −0.58 | −0.70 | −0.46 |
| ROE | −0.35 | 0.21 | −0.76 | 0.05 | −1.71 | 0.088 | −0.11 | −0.24 | 0.02 |

Abbreviations: Est., estimate; Std. Est., standard estimate; LL, lower limit; UL, upper limit.

**TABLE 5** | Indirect and total effects on social care.

| | | | | 95% CI | | | | |
|---|---|---|---|---|---|---|---|---|
| **Type** | **Effect** | **Est.** | **SE** | **LL** | **UL** | ***β*** | ***z*** | ***p*** |
| Indirect | LOC ⇒ SEA ⇒ SCA | −0.00 | 0.03 | −0.06 | 0.05 | −0.00 | −0.19 | 0.853 |
| | LOC ⇒ OEA ⇒ SCA | 0.01 | 0.03 | −0.04 | 0.06 | 0.00 | 0.43 | 0.665 |
| | LOC ⇒ UOE ⇒ SCA | −0.02 | 0.03 | −0.09 | 0.04 | −0.01 | −0.69 | 0.491 |
| | LOC ⇒ ROE ⇒ SCA | 0.01 | 0.01 | −0.02 | 0.03 | 0.00 | 0.41 | 0.685 |
| Component | LOC ⇒ SEA | 0.03 | 0.14 | −0.25 | 0.31 | 0.01 | 0.19 | 0.852 |
| | SEA ⇒ SCA | −0.18 | 0.11 | −0.39 | 0.03 | −0.15 | −1.72 | 0.086 |
| | LOC ⇒ OEA | −0.05 | 0.12 | −0.28 | 0.18 | −0.03 | −0.45 | 0.655 |
| | OEA ⇒ SCA | −0.21 | 0.12 | −0.44 | 0.03 | −0.14 | −1.74 | 0.082 |
| | LOC ⇒ UOE | −0.09 | 0.12 | −0.32 | 0.15 | −0.05 | −0.73 | 0.468 |
| | UOE ⇒ SCA | 0.26 | 0.12 | 0.03 | 0.49 | 0.18 | 2.17 | 0.030 |
| | LOC ⇒ ROE | −0.10 | 0.16 | −0.41 | 0.20 | −0.05 | −0.67 | 0.503 |
| | ROE ⇒ SCA | −0.05 | 0.10 | −0.24 | 0.14 | −0.04 | −0.51 | 0.610 |
| Direct | LOC ⇒ SCA | −0.33 | 0.17 | −0.66 | −0.00 | −0.14 | −1.99 | 0.047 |
| Total | LOC ⇒ SCA | −0.34 | 0.17 | −0.68 | −0.00 | −0.15 | −1.99 | 0.047 |

*Note:* Confidence intervals computed with method: Standard (Delta method). $\beta$ are completely standardized effect sizes.
Abbreviation: Est., estimate.

0.21, $t(177) = -1.71$, $p = 0.088$, did not significantly predict SDI at the conventional 0.05 significance level. These results suggest that among the EI variables, UOE and OEA are the most influential predictors of SDI, indicating that the ability to effectively use and understand emotions can significantly decrease the tendency to discriminate against others in social settings.

A multiple mediation analysis was conducted to examine the role of SEA, Appraisal of OEA, UOE, and ROE in the relationship between LOC and SCA.

Table 5 presents the indirect and total effects. First, the effect of LOC on each mediator was not statistically significant. Second, when controlling for LOC and the other mediators, only UOE significantly predicted SCA, $\beta = 0.18$, SE = 0.12, z = 2.17, $p = 0.030$. SEA, OEA, and ROE did not significantly predict SCA. The total effect of LOC on SCA was significant, $\beta = -0.15$, SE = 0.17, $z = -1.99$, $p = 0.047$, as was the direct effect of LOC on SCA, controlling for the mediators, $\beta = -0.14$, SE = 0.17, $z = -1.99$, $p = 0.047$. However, the indirect effects of LOC on SCA through each mediator were not significant. This suggests that the EI components we measured–understanding one's own emotions, understanding OEA, using emotions effectively, and regulating emotions–do not serve as pathways through which the frequency of contact with others affects the level of SCA expressed. Figure 1.

## 7 | Discussion

A quarter of the participants that took part in our study reported that they have a relative with mental illness. In relation to contact, our hypothesis was partly supported as only SCA and not the other factors of the OMI scale were significantly related to LOC. However, this correlation was negative. Higher levels of SCA were associated with lower levels of contact with people living with mental illness. In addition, LOC was a significant predictor of SCA, but this relationship did not appear to be influenced by the level of EI. Regarding the relationship between EI and attitudes, higher levels of SDI and social restriction, which represent negative attitudes towards mental illness, were associated with lower abilities of Appraisal of OEA

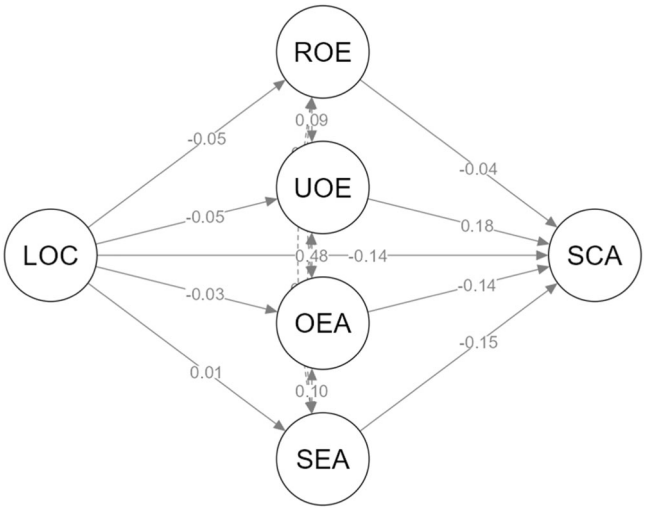


**FIGURE 1** | Indirect and total effects on social care.

and UOE. On the contrary, higher levels of SCA, which represent a positive attitude, were associated with lower SEA.

The finding related to contact and attitudes suggest the relationship between contact and attitudes is probably more complex than it was assumed and is limited to situations. More specifically, contact can vary depending on the strength of the relationship (Small 2017) and the intensity of strain (Gould 2003). For example, close and strong relationships can be a burden and cause stress (Offer and Fischer 2018), while weak ties may in some cases, lead to distance, but in others lead to cooperativeness and warmth (Small 2017). Thus, positive attitudes can be better predicted not simply by the presence of contact but by the characteristics of contact.

Corrigan and Nieweglowski (2019), suggest that the relationship between contact and attitudes is probably a u-shaped curvilinear relationship and not a linear relationship, where the highest levels of stigma are observed in people who do not know anyone with mental disorders (upper left half of the curve) and people with the most intimate relationships with these individuals (upper right half of the curve). The authors suggest that burden (i.e., the responsibilities of taking care of those with mental illness) explains the increase of negative attitudes. Thus, negative attitudes towards people with mental Illness are not merely a product of lacking knowledge or because even people with high levels of contact and intimate relationship can have negative attitudes towards people living with mental illness (Gibson Watt et al. 2023). Thus, what it seems to play an important role in the relationship between contact and attitudes is the quality of the relationship and not merely the presence of contact (Ran et al. 2022).

To date, previous studies conducted in this field have used (a) traditional contact interventions, in which participants experience direct, face-to-face contact with a person with mental illness (Martínez-Hidalgo et al. 2018), (b) indirect contact interventions where participants observe another individual interacting with a person living with mental illness (West and Turner 2014), (c) imagined contact, where participants visualize themselves interacting with a person living with mental illness (Na and Chasteen 2016), d) contact via video, in which participants view a person with mental illness on film (Penn, Chamberlin, and Mueser 2003). Some other studies examined the level of familiarity or intimacy with people with mental health problems (Holmes et al. 1999). This means that contact was operationalised in different ways by different studies and a more in-depth investigation is needed on the meaning and the type of contact to understand when and why contact should be expected to affect attitudes.

Addressing the gap in the literature, in relation to EI, the findings of the present study demonstrate that those with high levels of SEA, Appraisal of OEA and stronger UOE skills express less negative attitudes towards members of other groups. This supports previous research (Makwana et al. 2021; Onraet et al. 2015) and confirms that EI plays an important role not only in an interpersonal level but also when considering intergroup dynamics. Moreover, EI was as predictor of attitudes towards mentally ill individuals. Specifically, higher abilities of UOE and OEA emerged as significant predictors of lower levels of SDI. It seems that individuals with a greater ability to use their emotions effectively and perceive OEA accurately may be less likely to exhibit negative attitudes towards individuals living with mental illness.

These findings highlight the importance of EI and especially the abilities to use emotions effectively and understand OEA in affecting attitudes towards members of other groups. SEA, and ROE did not significantly predict SDI. This might suggest that abilities about oneself (i.e., understanding and managing one's own emotions), do not directly influence attitudes towards others. Establishing a relationship between some aspects of EI and attitudes towards members of other groups demonstrates that individual differences also play an important role in intergroup relations and should be taken into consideration when planning interventions to reduce prejudice. These interventions could focus on cultivating abilities such as UOEs and understand OEA to build better intergroup relationships. Given that the ability to understand and use emotional information may be the foundation for making good decisions (Mayer, Caruso, and Salovey 2016; Mayer and Salovey 1997) and improve the quality of group relationships (Côté et al. 2011), these EI dimensions could probably play an important role in affecting attitudes towards other groups.

Contrary to our expectations, when EI was taken into account as a mediator, the association between LOC and Social Care (SCA) was not significantly mediated by dimensions of EI. Despite the significant direct effect of LOC on SCA, the indirect effects of EI dimensions (SEA, OEA, UOE, and ROE) were not significant. This implies that, while LOC is a significant predictor of SCA, this relationship does not appear to be influenced by the level of EI. These findings contribute to our understanding of the complex relationship between LOC with mental illness, SCA, and EI, and suggest that other factors may play a more crucial role in mediating this relationship. For example, maybe future studies could examine the role of some other abilities or personality traits. Some studies have already found that people who exhibit higher empathy, tended to have fewer negative attitudes towards them (Szeto, O'Neill, and Dobson 2015). In addition, Brown (2012) and Yuan et al. (2018), using the Big Five

model of personality, showed that openness and agreeableness were negatively associated with stigmatization towards people living with mental illness. More research is needed to clarify and extend these findings throwing further light on the importance of EI in intergroup dynamics.

The study has practical implications, as the findings provide new avenues for the development of stigma reduction interventions in intergroup relations. More specifically, they indicate the importance of the role of EI of the general population when planning interventions and public health campaigns which aim to reduce the stigma towards mental illness. By recognizing the impact of EI on attitudes, targeted interventions can be developed to enhance empathy and understanding within communities, ultimately promoting an inclusive society. The results of this study can also be used to design educational programs that integrate EI and mental health awareness into school curricula. Such programs can equip young people and children with the skills and knowledge to support their peers experiencing mental health issues, contributing to early intervention and a supportive school environment. In addition, the findings of this study can be used as guidance by policymakers in formulating legislation and policies that address mental health stigma and discrimination.

Some anti-stigma campaigns have assumed that high levels of contact with individuals living with mental illness will lead to reduction in stigma. However, the evidence on the effectiveness of contact-based interventions is weak since high levels of contact have not been associated with positive attitudes with mental illness as it can be seen by this study and other studies conducted in this field (Angermeyer and Dietrich 2006). A fertile area for future work is to examine the pathways through which contact with people with mental disorders influences attitudes towards them to develop more effective anti-stigma strategies and interventions. This type of research can increase the relevancy and effectiveness of contact interventions.

## 8 | Limitations

The present study has a number of limitations. An important one is the collection of data through self-reporting measures which may consciously or unconsciously influenced by "social desirability." Thus, participants were more likely to give the more socially acceptable answers rather than being truthful. In addition, they might be inherently biased by their feelings at the time they filled out the questionnaire. If they felt bad at that time, they filled out the questionnaire, for example, their answers would be more negative and if they felt good at that time, then their answers would be more positive. Future qualitative studies could provide deeper insights into how different interactions shape perceptions and attitudes, enriching the field's understanding of effective stigma reduction strategies. Another limitation is the small number of participants and the unequal gender sample since females were overrepresented. This probably had an effect on findings since some researchers (Ng and Chan 2000) have found that females tended to have less stigmatizing attitudes towards people living with mental illness. In addition, another factor that should be taken into consideration by future research is the heterogeneity of mental illness which can range from mild to severe symptoms. In this study, the attitudes towards people living with mental illness in general were examined, instead of attitudes towards people with specific types of mental illness. Different forms of mental illness and severity levels may face different attitudes. Greater attention to mild and moderate mental disorders is therefore needed.

## 9 | Conclusion

Overall, the findings of this study provide new avenues for the development of stigma reduction strategies and interventions regarding social mental health stigma. Further research may consider the role of EI more widely in this area as well as in intergroup relations in general, as it seems to offer promising directions in planning prejudice reduction interventions. Regarding contact, it will be equally powerful for future research to examine the pathways through which contact with people living with mental illness influences attitudes towards them to develop more effective anti-stigma strategies and interventions. In addition, the differentiation between examining attitudes towards people with mild and moderate mental illness should be taken into consideration by future research. Only through effective mental health stigma reduction strategies, can mental health stigma which has adverse outcomes not only for the individuals but for the society as a whole, be reduced in Greek society.


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### Ethics Statement

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and national research committee and with the 1964 Helsinki declaration and its later amendments. The research protocol received approval from the Ethics Committee of the Mamatsio General Hospital of Kozani under the number 88/2023.

### Conflicts of Interest

The authors declare that they have no competing interests in this work, that this is original research which has not been published before and it is not under concurrent consideration elsewhere.

### Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

### Peer Review

The peer review history for this article is available at https://www.webofscience.com/api/gateway/wos/peer-review/10.1002/jcop.23162.

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