TYNDALE UNIVERSITY
3377 Bayview Avenue
Toronto, ON
M2M 3S4
TEL:
416.226.6620
www.tyndale.ca

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Emotional Intelligence and Perspectives on Mental Health: Comfort and Compassion Towards Persons with Mental Illness

Renée Lehman

Tyndale University

Abstract

The current study sought to evaluate a person's emotional intelligence (EI) and the variables that contribute to perspectives of comfort and compassion towards individuals with a mental illness (MI). Patterns in demographics, personal or family history of mental illness and overall level of compassion of participants were explored. Participants responded to a series of mental illness case studies (MIS) to determine their feelings of compassion and levels of comfort in various situations. Emotional intelligence (measured with the TEI-Que-SF) and overall compassion (measured with the Compassionate Love for Humanity Scale) were also measured. A positive correlation was found between overall compassion scores and each MIS outcome. TEIQue-SF subscales well-being, self-control, emotionality and overall compassion, were significant in predicting compassion and comfort towards persons with MI. Participants with a personal history with MI scored lower in total EI than people without a personal history with MI, and well-being and self-control were related to people's personal history with MI. Having a personal history of MI did not show a positive correlation to levels of comfort or overall compassion towards MIS characters but was correlated with compassion towards MIS characters. EI (via TEIQue-SF) was not always associated with high compassion (via MIS). Future research might benefit from using more detailed and varied case studies, or an entirely alternate method of exposure to MI.

The experience of a mental illness (MI) is unique to the individual who perceives it. How others perceive this illness may depend on a variety of factors. Presumably, one's own emotional intelligence (EI) may play a role in this perception. EI can be defined as the capacity to perceive and understand emotions and the ability to use this information as part of decision-making and management of behaviour (Copestake, Gray & Snowden, 2013). According to Davis, Conklin, Smith and Luce (1996), a well-developed ability to take another's perspective allows individuals to overcome usual egocentrism, tailor behaviours to others' expectations, and make satisfying interpersonal relations possible. With acknowledgement of the connections amongst perception, compassion and EI, the following study asks: in what ways is EI related to how an individual perceives someone else's mental health? Specifically, how does EI influence a perceivers' feeling of comfort and compassion towards individuals with MI?

Emotional Intelligence

According to Petrides, Pita, and Kokkinaki (2007), Emotional Intelligence (EI) is the ability to perceive and understand emotional processes and to regulate them effectively. In order to feel compassion for someone, it is necessary to understand the relationship between the self and others. This involves the concern for those who suffer or are vulnerable, and the motivation to enhance the welfare of others (Eisenberg, 2002). Perspective plays a distinct role in understanding the inner workings of another person's mind. Studies of EI have established differences in a person's ability to effectively perceive, relate to, and understand oneself and others (Zins & Elias, 2007). With regards to monitoring an individual's own mind and their EI, this plays a distinct role in regulating emotion (Graziano & Bryant, 1998).

The current study will use the Trait Emotional Intelligence Question Short Form (TEIQue - SF) to measure its participants' EI, which refers to a constellation of emotional self-perceptions located at the lower levels of personality hierarchies (Petrides, 2009). Trait EI provides an

interpretive framework for the majority of EI measures, which assess typical performance (Siegling, Vesely, Saklofske, Frederickson, & Petrides, 2017). Use of the TEIQue Adolescent Short Form (TEIQue – ASF) with two European secondary school samples indicated reasonable reliability and validity when used with adolescents. Siegling et al. (2017) measured the incremental validation of the scale as a predictor of socioemotional (depression, somatic complaints, and social competence) or academic achievement criteria. Through evaluation of the incremental validity of the TEIQue – ASF, a clear conception of the predictors of factors derived from TEIQue-ASF results, like coping strategies, may provide a more developmentally appropriate and meaningful proxy conceptualization of personality (Siegling et al., 2017). Thus, Siegling et al., were able to predict various elements in personality and cognitive ability based on participants scores of EI derived from the TEIQue-ASF. Siegling et al., 2017 validated the usefulness of the TEIQue ASF in this European sample by showing its ability to predict certain variables.

Pekaar, Bakkar, Born, and Van de Linden (2019) evaluated EI and the focus on the self and others within an emotionally demanding job task. Using phone calls that were pre-recorded by semi-professional actors, Pekaar et al.(2019) captured four emotionally stimulating scenarios (anger, sadness, enthusiasm, and elatedness). Adhesive electrodes were attached to the participant's fingers for skin conductance recordings while they listened to phone calls in the work context of a secretary. In using 28-item Rotterdam Emotional Intelligence Scale (REIS; Pekaar et al., 2018)., Pekaar et al. (2019) found that EI dimensions of self-focused emotion appraisal, self-focused emotion regulation, other-focused emotion appraisal, and other-focused emotion regulation, can play a critical role in the prediction of task performance, stress, and physiological arousal during an interpersonal emotion regulation task.

Promoting a healthy EI in young students may encourage compassion for individuals with a MI. Greenberg, Weissberg, O'Brian, Zins, Resnik, and Elias (2003) explored the mission in schools

to educate students to be knowledgeable, responsible, socially skilled, healthy, caring, and contributing citizens. In their study, Greenberg et al. (2003) reviewed evidence that indicated school-based prevention and youth development interventions are most beneficial when they simultaneously enhance students' personal and social assets, such as social awareness, enhanced academic learning performance, limited drug use, and overall positive youth development. Their results suggested that teaching children to apply social and emotional learning skills and ethical values helped to foster respectful and supportive relationships among students, school staff, and parents (Greenberg et al., 2003). As well, these learning skills helped support positive social, health, and academic behaviour (Greenberg et al., 2003).

Mindfulness training can also further facilitate beneficial relationships amongst persons when connections are approached with a mindful knowledge of the self (Slutsky, Chin, Raye & Creswell, 2018). In relation to EI, mindfulness can help regulate one's work and personal life dynamics by providing resources to more effectively cope with work-related cognitions and emotions, which may also influence general EI and knowledge of oneself (Michel, Bosch, & Rexroth, 2014). Slutsky et al. (2018) conducted a six-week program in mindfulness training among employees of a Midwestern marketing firm. Their results indicated improvement in attention, focus at work, and a decrease in work–life conflict and job productivity with the integration of mindfulness training (Slutsky et al., 2018). Thus, studies that confirm the positive effects of mindfulness and therefore indirectly the positive effects of increased EI on interpersonal interaction, may suggest a similar link between studies between EI and compassion and comfort for a person with a MI.

Culture

Cultural perspective and the understanding of oneself and others may play a role in an individual's levels of comfort and compassion for people with a MI Sparkman, Eidelman,

Dueweke, Marin, and Dominguez (2019) explored openness to perspective taking and predicting factors of multiculturalism and colorblindness. Sparkman et al. (2019) measured openness to experience, ethnic perspective taking, multiculturalism (cultural diversity), colorblindness, empathy and demographics. Ethnic perspective taking refers to the participants' ability to both understand and accurately perceive cultural practices and differences among people groups (Sparkman et al., 2019). They found that openness to experience and multiculturalism are positively related and supported the claim that ethnic perspective taking mediates the relationship between openness and multiculturalism. When addressing compassion for others, a person's openness may play a similar role in the comfort one feels when interacting with people with a MI.

When learning to see things from another person's point of view, a form of relationship is often involved. Relational mobility has been defined as how individuals in a given social context perceive how they are able to form and terminate relationships (Schug, Yuki, & Maddux, 2010). San Martin Schug, and Maddux, (2019) used six studies to explore diverse cultures like those found in the United States, Spain, Israel, Nigeria, and Morocco. In these cultures, patterns of dispositional bias attention were predicted, referring to the designation of certain qualities as being an internal characteristic of a culture. The study measured analytic (methodological and structured) and holistic (overseeing circumstances as a whole) thinking (San Martin et al., 2019). Through evaluating one's openness to experience in perspective taking and its prediction to colorblindness, San Martin et al (2019) confirmed that individuals in cultures that show lower levels of relational mobility would tend to show more attention to surrounding social and physical contexts. While MI is a very different kind of personal characteristic than culture, people with MI can experience similar kinds of bias, and therefore can also benefit when those around them are better able to see things from alternative perspectives.

Some researchers have explored the interaction between perceptions of culture and MI. MI present within an individual, or seen in another, is often experienced through the lens of pre-existing thoughts or feelings one attributes to this particular illness. Nathan, Wylie and Marsella (2001) explored the role of ethno cultural factors that might contribute to these attributions. Nathan et al. (2001) focused on ethno cultural groups of primarily European-American, Filipino-American, Hawaiian/part-Hawaiian, and Japanese-American participants. Using an Attribution Interview Schedule (AIS), Nathan et al. (2001) used open-ended interviews to assess participant's attributions about the nature, cause, and best treatment of MI. They found participants of various ethno-cultural groups to have attributions towards particular illnesses in many areas. These included stress as a cause, and the idea that medical intervention and counselling were the best treatments for MI (Nathan et al., 2001).

The impact of prior experience with MI on one's current perceptions of another person with MI may reflect the ways in which perceived similarity of any kind might influence judgment of others. Thielmann, Hilbig, and Zettler (2018) explored assumed similarity and defined it as the correspondence between how people describe themselves and others (Thielman et al., 2018). Ashton, Lee, and Devries (2014) included the personality traits of honest-humility, emotionality, extraversion, agreeableness, conscientiousness, and openness to experience in the acronym HEXACO. Theilman et al. investigated assumed similarity of HEXACO personality traits among strangers. They found assumed similarity affects the traits most strongly linked to personal values; honesty-humility and openness to experience. These results indicate that assumed similarity does not merely result from a lack of information, but that others share basic parts of one's identity, even if these others are complete strangers (Theilman et al., 2018).

The participants of the current study are asked to reflect on their perception of characters showing symptoms of a MI. Theilman et al. (2018) conducted research on assumed similarity of

personality traits, and how assumed similarity can reflect the assumption that others share basic parts of one's identity. The understanding of this assumed similarity may help explain the factors that contribute to a particular perception held by the participants in Thielman et al.'s study. According to Theilman et al., it is reasonable to assume that an individual who has a MI themselves would respond differently according to their own assumed similarity to the characters being portrayed in the study. There is a significant focus on perception in the current study's research of its participant's comfort and compassion towards individuals with a MI.

Regardless of whether or not participants have a MI themselves, every person has developed their own perception of the world around them. A person's perception of an individual leads to the ways they might place judgement on them. These judgments might be based on factors like a negative isolated incident with a person with a MI, or improper mental health education. An example may be the perception of someone as 'deviant' or 'dangerous', leading to different responses than perceiving someone as 'unwell' or 'eccentric'. If a person's perception is in fact inaccurate, the development of stigma can occur and lead to future negative perceptions of MI in others.

An individual's perception of a MI is often affected by a specific stigma surrounding it. Dupont-Reyes, Villatoro, Phelan, Painter and Link (2019) examined how stigma around MI varies across race, ethnicity, and gender in young adolescents (11- to 13-years-old). Similar to the current study, they evaluated their participant's demographics across age, race, ethnicity, gender, and socioeconomic status. Dupont-Reyes et al. (2019) found that boys and Latina/o adolescents reported greater stigma for some outcomes than girls and white adolescents (Dupont-Reyes et al., 2019). Ultimately, Dupont- Reyes et al. (2019) generated new knowledge about how differences in MI-related knowledge, positive attitudes, and behaviors toward peers with views about MI exist across racial and ethnic identity, and how gender intersects with these perceptions. They found that

the race, ethnic, and gender patterns found in MI stigma in adolescence, mirrors the literature among adults. This indicates that MI-related stigma crystalizes early in life and persists into adulthood (Dupont-Reyes et al., 2019).

Self Monitoring (SM) is defined as the extent as to which an individual monitors, through self-observation and self-control, their expressive behavior and self-presentation (Snyder, 1979). Self-attribution is a person's tendency to formulate naive causal explanations, or attributions, for the events that they perceive to occur (Snarr, Slep & Grande, 2009). Self-regulation is a factor that may influence how individuals respond to others with MI. Graziano and Bryant (1998) researched self emotional regulation in relation to SM. To conduct their research, Graziano et al., used the Valins heart-rate feedback paradigm (Valins, 1966), that measured the participants heart rate increase when viewing particular persons in image slides to measure physical attraction. Graziano et al., also used the Olson humour paradigm (Olson, 1990), which had participants read joke monologues to investigate factors associated with perception of humor. Their results indicated that individuals temperamentally disposed to emotional reactivity and who experience inconsistent social outcomes for emotional expression, may develop systems to separate their affective states from their behaviors (Grazio et al., 1998). They concluded that SM might be related positively to reliance on external cues in the self-attribution of emotion (Grazio et al., 1998).

Education on Mental Health

The current study requires its participants to define their perspective of particular forms of MI expressed through characters in various case studies. In doing so, their previous knowledge or education about a particular MI may influence their perception of these characters. Many studies have explored the connections between education on the topic of mental health and the attitudes held in relation to MI. Brucker and Doty (2018) measured the attitudes of community mental health

agency staff and employees for persons with a serious MI. With use of an online survey, the study was distributed across 4 different community mental health centers across New England State. Brucker and Doty's (2018) results indicated a mix of views on benefits of work, the client's ability to handle the demands of the worker role, and client's motivation to work for employees with serious MI. Ultimately, staff with higher levels of education in general held significantly more supportive views than those with less education. Brucker and Doty's (2018) study suggests that an open and accepting view towards MI may be based on the education levels of a perceiver. For the current study, this may suggest that participants with higher levels of education may show higher comfort and compassion towards persons with a MI.

Clearly, the particular attitudes that surround MI will vary for every individual. These attitudes may be affected through the general education level of an individual, given that educated individuals often have the knowledge to approach situations with reason and practicality. The accurate knowledge and exposure to the characteristics of MI, as well as general knowledge through basic education, may help to further an individual's acceptance and understanding of MI. Presentations such as the National Alliance on Mental Illness (NAIM) and Ending the Silence (ETS) have been established to further this understanding and acceptance in young people particularly. Using 10 different high schools, Wahl, Rothman, Brister, and Thompson (2018) sought to evaluate the effectiveness of NAIM and ETS presentations. Immediately after, and four to six weeks after the presentations, the students in the study completed a 12-item questionnaire. This evaluated the student's knowledge of mental health conditions attitudes/social distance preferences, and help-seeking levels (Wahl et al., 2018). For the students that received the presentation, a significant improvement was shown in each of these areas for both individual and overall scores. Wahl et al.'s (2018) findings suggest tools like the NAIM and ETS can be valuable

when educating youth about mental health conditions. Furthermore, programs such as these may contribute to future generations' acceptance and understanding of MI (Wahl et al., 2018).

The accuracy of the perceptions people hold about mental health may play a role in their comfort and compassion towards people with a MI. Srike, Skovholt, and Hummel (2004), used the Counselling Clients with Disabilities Questionnaire (CCDS; Stike, 2001) to measure mental health professionals' self- reported competence when working with clients with disabilities. Participants in this study reported being most competent in awareness, less competent in knowledge, and least competent in skills towards clients with disabilities (Strike et al., 2004). These findings indicate a need for mental health professionals to become more educated in these particular areas. Although Strike et al. (2004) focused on professional competence within their study, the relevance of self-concept is applicable to every individual.

The Present Study

The present study measured participants' EI using five subscales (well-being, compassion, self-control, emotionality, sociability) and their levels comfort and compassion. To measure these factors, the TEIque-SF EI test (Petrides, 2009) and the Compassionate Love for Humanity Scale (Sprecher & Fehr, 2005) were used.

As noted above, Siegling et al. (2017) found that the relationship between compassion and EI may be relevant to an individual's perception of persons with a MI, as the social engagement with individuals who have a MI can be a reflection of EI levels. Pekaar et al. (2019) measured the EI dimensions that focus on the self and others through the 28-item Rotterdam Emotional Intelligence Scale (REIS; Pekaar et al., 2018). Understanding the particular measures of EI that focus on the self may play a role in one's perception of mental health and influence their compassion towards a person with a MI. The focus on oneself might contribute to the ability to relate and feel compassion towards others. This information established through the results of

previous studies researching the understanding of the self, may play a role in interpreting the emotional state of others within the present study. Particularly, as self-understanding can contribute to relatability, and may influence feelings of empathy and compassion for others. Greenberg et al. (2003) study of school based prevention and youth development interventions focused on emotional learning and the effect on interpersonal relationships. If such programs can be used to increase emotional learning, this supports the notion that EI can be taught, which may further foster an increase in compassion.

San Martin et al. (2019) focused on the different psychological processes of different cultures and evaluated the impact of recognizing diversity amongst these cultures. The variable of culture was explored in the current study to examine cultural influence in relation to a participant's perception of MI. They provided evidence of a relationship between a specific culture, and the likelihood of said people group to show comfort or compassion towards persons with a MI. Reflections on the types of attributions people make about MI may provide further insight to other connections in perceptions of mental health, exemplified in Nathan et al.'s study previously described.

Dupont-Reyes, Villatoro, Phelan, Painter and Link (2019) employed a research methodology that inspired aspects of the present study. Their method mirrors that of the current study in its use of characters presenting forms of MI through case studies. Dupont-Reyes et al. used two characters described as meeting The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013) criteria. These portrayed characters were individuals experiencing symptoms of bipolar and social anxiety (Dupont-Reyes et al., 2019). In addition to their responses to specific MI case studies, aspects of respondents' own mental health experiences were measured. The present study focuses on its participant's levels of comfort

and compassion towards individuals with a MI and includes measurement of the mental health of the participant as well.

Graziano et al. (1998) found that regulation of self monitoring, may influence a persons' perception of an individual with a MI. Particularly, the element of self control and the understanding of one's emotional limitations and developed perceptions may influence their compassion or judgement when responding to a person with a MI. For example, the element of expressive behaviour associated with self monitoring might influence a person's expressive behavioural response to a person with MI. Given the current study's focus on perception of comfort and compassion towards persons with MI, it might be reasonable to expect participants to attribute their reactions to said persons based on their own SM skills, and the systems they may develop to personally make sense of the characters with MI.

The participants in the current study were asked to personally reflect on stories of characters with a MI. Given this request, the participant's prior education on mental health may influence these responses. It is important to acknowledge that levels of education will vary amongst every individual. Understanding the variety in these levels, in relation to other factors such as age, culture or occupation, may suggest that those with more education will be better prepared to moderate their initial emotional reactions to the cases, and respond with more comfort and compassion.

It was hypothesised that the participants resulting in a higher EI, would also show higher results in the Compassionate Love for Humanity Scale (Sprecher & Fehr, 2005). Moreover, it was predicted that participants with a personal or family history of MI would score higher in the EI and compassion scales, and show higher levels of compassion and comfort when responding to the characters with a MI.

Method

Participants

The study involved 77 adult participants living in Southern Ontario. It was advertised over the social media platforms of Facebook and Instagram through a text post, on wall posters, and through word of mouth. Participants included 68 individuals ages 18 - 25, five individuals ages 26 - 35, and four individuals ages 36 – 59.

The majority of the participants were students in their undergraduate program at Tyndale University. Other participants were from London Ontario and the Greater Toronto area (Mississauga, Oakville, Kitchener, etc.). The gender of participants included 53 females (69%), and 24 males (31%). Regarding ethnicity, 15 (20%) participants identified as 'Other North American Origins', 44 (57%) 'European Origins', 9 (12%) 'Caribbean Origins', 6 (8%) 'Latin, Central and South American origins', 10 (13%), 'African Origins', 14 (18%) 'Asian Origins', 1 (1%) 'Oceania Origins', and 3 (4%) chose and specified 'other Origins'. Regarding religious affiliation, 74 (96%) participants identified as Christian, 2 (3%) identified as Catholic, 1 (1%) chose Hindu, 1 (1%) chose Buddhist, and 1(1%) identified as Agnostic. Of the 77 participants 69 (90%) were students, 7 (9%) were part time students, 4 (5%) had full time jobs, and 20 (26%) had part time jobs.

With regards to previous personal mental health conditions, 17 (22%) participants said they had been diagnosed with a mental illness (MI) for 2 or more years, 2 (2.6 %) had been diagnosed within the past year, 14 (18%) had a suspected but undiagnosed MI and 43 (56%) had no personal history of MI. Participants described their suspected but undiagnosed cases of MI in the form of anxiety, depression, and attempted suicide. When asked about the history of MI in immediate and extended family members, 13 (17%) participants had no history of MI in either extended or immediate family. Participants who had immediate family members with a diagnosed MI came to 24 (31%), and 29 (38%) had suspected but undiagnosed MI in immediate family members. The

diagnosed MI in extended family members included 27 (35%) participants, and 14 (18%) had suspected but undiagnosed MI in extended family members. The number of participants that were unsure of their family history in MI was 15 (19%).

Apparatus

The study took place in a private room that was small and conference style, with neutral coloured walls, 9 -10 desk chairs, a large common table and a pen at each setting. Upon entering the room, participants completed an informed consent form (see Appendix A). Along with explaining what was expected of them in this study, this form explained the risks and potential emotional reactions that may emerge in the exposure to the study's MI case study stories (MIS). The materials found in the booklet labeled "Research Documents" (see Appendix B for copy), contained five different MIS, depicting cases of Anxiety, Schizophrenia, Obsessive Compulsive Disorder (OCD), Depression and Bipolar disorder through various character cases. As illustrated in Appendix B, following each of the five MIS were four MIS response questions, which measured the participants' compassion and comfort towards individuals with MI. These variables were measured through questions such as, "I would be willing to sit next to X in a public place (restaurant, public transit, etc.)". Every "a)" and "c)" question measured the participant's level of comfort towards the character displaying a MI. The measurement of compassion towards individuals with MI was measured using every question "b)" and "d)". The results of the MIS questionnaire were evaluated through a Likert scale (disagree being 1, agree being 7). Each variable was measured using five (out of the 20) questions in the MIS questionnaire, with a highest possible score being 35. The researcher found the average of these five particular questions and deciphered the participant as being 'high' or 'low' in this category.

The next section of the booklet contained the Trait Emotional Intelligence Questionnaire (TEIQue-SF) found in Appendix C (Petrides, 2009), and the Compassionate Love for Humanity

Scale found in Appendix D (Sprecher & Fehr, 2005). The TEIQue-SF measured subscales of well-being, self-control, emotionality, sociability and total EI. Well-being was measured using questions such as, "I feel that I have a number of good qualities". An example question measuring self-control was, "On the whole, I'm able to deal with stress". Emotionality was measured with, "I often pause and think about my feelings", and sociability was measured with "I can deal effectively with people" (Petrides, 2009). An example of a question used in the Compassionate Love for Humanity Scale was, "I would rather suffer myself than see someone else (a stranger) suffer" (Sprecher & Fehr, 2005).

O'Conner, Nguyen and Anglim (2017) studied the reliability of the TEIQue-SF and coping with task stress, showing an internal reliability of α =.88 for the TEIQue-SF for their study. The Compassionate Love for Humanity Scale (Sprecher & Fehr, 2005) has demonstrated to be reliable through a study demonstrating Cronbach's alpha as .95 for each version of the scale.

Following the scales was a demographic survey that recorded the participants' gender, age, religious affiliation or belief system, ethnicity, occupation, and personal and family mental health history (see Appendix E). The last element of the study was a page thanking the participant for their contribution to the study, along with a space for any additional comments regarding their experience with mental health (see Appendix F).

Procedures

The study was executed on October 23rd, 24th, 25th and 26th between 10 a.m. to 12 p.m. on the 23rd and 24th, 12 p.m. to 2 p.m. on the 25th, and 1 p.m. to 3 p.m. on the 26th. Due to a limited number of participants in the first round, the study was conducted for a second session on November 6th from 4 p.m. to 7 p.m., 7th from 11:30 a.m. to 2 p.m., and 8th from 4 p.m. to 8 p.m.

Once settled in the room of the study the participants were reminded in the informed consent form that they may exit at any given time. Once receiving the study's booklet, the contents

had various documents, which have been outlined in the apparatus and can be found in the Appendices. After completing the booklet, participants handed their documents to the researcher who was present at a seat at the end of the table in the room.

There was no time limit imposed on participants, although the materials were designed to take under an hour to complete. The informed consent form provided each participant with the contact information of the Tyndale University counselling center to be accessed at any time, and participants were offered (not required) to take a form with them after completing the study. On the last page of the informed consent form, participants recorded their name and student number for 1% extra credit. If the participant was not enrolled in a psychology course at Tyndale University, then they were placed in an entry to win a 25$ Amazon gift card.

Results

Descriptive Statistics

The participant's results of EI and overall compassion were derived from the Trait Emotional Intelligence Questionnaire, known as the TEIQue-SF (Petrides, 2009), and the Compassionate Love for Humanity Scale (Sprecher & Fehr, 2005). The scores were computed using the original scoring method for each test. The mean, standard deviation and number of participants for the TEIQue-SF scale as well as the Compassionate Love for Humanity Scale were comparable to typical results with these tests and are displayed in Table 1.

Table 1: *Descriptive statistics for TEIQ-SF variables and overall compassion*

Statistic	Well-Being	Self Control	Emotionality	Sociability	Total	Overall Compassion
Mean	5.6061	4.5411	4.9838	4.8092	5.0276	5.6790
SD	.64110	.90155	1.03349	.70313	.96942	.85817
N	76	77	77	76	76	77

Four specific questions were asked to assess respondents' comfort with and compassion toward each of the five cases described in the case studies. The first and third questions assessed

respondents' comfort interacting with the individuals (e.g. would be willing to sit beside X in a public place; comfortable giving X directions), while the second and fourth questions assessed respondents' feelings of compassion with the individuals (e.g. have concern for X and her/his future; have compassion for X and her/his challenges). Therefore, a MIS *comfort* score was computed by averaging responses to the first and third questions for all five case studies, and a MIS *compassion* score was computed by averaging responses to the second and third questions for all five case studies.

Table 2: *Descriptive Statistics for MIS Variables*

	Q1 sit next to	Q2 Concern for	Q3 Give Directions	Q4 Feel Compassion	MIS Comfort (Average of Q1&3)	MIS Compassion (Average of Q2&4)
Mean	5.9740	6.1247	6.4208	6.0026	6.1974	6.0636
SD	.62606	.92169	.46745	.86966	.49257	.75549
N	77	77	77	77	77	77

Hypothesis Testing

The initial hypothesis predicted that the EI subscales would be positively correlated with responses to the MIS case studies. To test this hypothesis, a series of bivariate correlations was computed between each EI subscale and responses to each of the MIS questions, and also between the EI subscales, and the MIS comfort and MIS compassion scores, which were based on those MIS questions. Additionally, correlations between the overall compassion scores (based on the Compassionate Love for Humanity Scale) and each MIS outcome were computed. These correlations are reported in Table 3.

Table 3: *Correlations between EI subscales and MIS questions.*

EI Subscale	Q1 Sit next to	Q2 Concern for	Q3 Give directions to	Q4 Feel compassion	MIS Comfort	MIS Compassion
Well-Being	.097	.049	.206*	.013	.159	.037
Self Control	.219*	-.136	.264**	-.150	.264*	-.169
Emotionality	.016	195*	-.120	.160	-.047	.211*

Sociability	-.057	-.012	.037	-.153	-.018	-.095
Total TEIQ	.114	.059	142	-.017	.140	.026
Overall Compassion	.021	.355*	-.165	.559*	-.065	.538*

Note 1: MIS Comfort is the average of items Q1 and Q3, while MIS Compassion is the average of Q2 and Q4.
Note 2: Matrix scatterplots were created to allow visual inspection of each of these correlations and are included in Appendix F.
Note 3: * $p < .05$

The measurement of well-being was positively related to people's comfort with giving directions to the MIS character. Results of self-control showed a positive relationship with participant's comfort with sitting next to and giving directions to the MIS character, and their average level of comfort for the MIS characters. Thus, people with higher well-being or self-control were more comfortable with the MIS characters. Emotionality was positively related to people's concern for and overall compassion for the MIS characters. This demonstrates that people with high emotionality also showed higher levels of compassion towards MIS characters. Finally, overall compassion was positively related to the various measures of compassion toward the MIS characters. Thus, high amounts of overall compassion were related to higher amounts of compassion towards MIS characters.

The participants who showed higher compassion in case study results, also showed higher overall compassion through the compassion scale. This relationship confirms the validity of the MIS questions measuring compassion given the reliability of the Compassionate Love for Humanity scale (Sprecher & Fehr, 2005).

Given that individuals who have had some experience with MI may respond differently to others with MI, a series of independent samples T-tests was carried out to test the hypothesis that personal MI history would be related to comfort with and compassion towards people with MI. See Table 6 for the mean scores of MIS comfort, MIS compassion and overall compassion for those with or without personal MI history. The only one of these three comparisons that was

significant pertained to compassion toward the MIS characters. Specifically, people with some personal MI history felt more compassion in response to the MIS than individuals with no personal MI history, $t(75)= 2.458$, $p<.05$.

Table 6: *Mean MIS comfort, MIS compassion and overall compassion for those with MI personal history (n= 34) and those with no personal history (n=43)*

MI Personal History	MIS Comfort	MIS Compassion*	Overall Compassion
Some MI Personal History	6.08	6.29	5.81
No MI Personal History	6.29	5.88	5.58

Note: * $p < .05$

To test the hypothesis that personal history with MI would be related to EI, an additional series of independent samples T-tests were carried out to test the hypothesis. See Table 7 for the mean EI scores based on personal history with MI. People with personal history with MI scored lower in total EI than people without a personal history with MI, $t(74) = -3.048$, $p < .01$. Additionally, the subscales of well-being $t(75) = -3.170$, $p <.01$, and self-control $t(75) = -3.056$, $p < .01$ were related to people's personal history with MI. Again, people with a personal history of MI scored lower.

Table 7: *EI for those with MI personal history (n= 34) vs. no personal history (n=43)*

MI Personal History	Well-Being **	Self-Control**	Emotionality	Sociability	Total EI**
Some MI Personal History	5.26	4.16	4.93	4.64	4.78
No MI Personal History	5.88	4.84	5.02	4.94	5.21

Note: * $p < .05$

To further explore the impact of previous experience with MI, a series of independent samples T-tests were carried out to test the hypothesis that MIS comfort, MIS compassion and overall compassion along with EI would be related to family history with MI. See Table 8 and 9 for the mean MIS comfort, MIS compassion, overall compassion and EI scores based on family history with MI. There were no significant results shown in relation with family history of MI.

Table 8: *MIS comfort and compassion with overall compassion for those with MI family history (n= 63) vs. no family history (n=13)*

MI Family History	MIS Comfort	MIS Compassion	Overall Compassion
Some MI Family History	6.18	6.09	5.7
No MI Family History	6.25	5.9	5.56

Table 8: *EI for those with MI family history (n= 63) vs. no family history (n=13).*

MI Personal History	Well Being	Self Control	Emotionality	Sociability	Total EI
Some MI Family History	5.55	4.5	4.93	4.73	4.97
No MI Family History	5.89	4.74	5.22	5.18	5.31

Subject Demographics

Several tests explored the impact of the demographics of gender culture and religion of participants in their responses to the MIS. No significant differences were found between males and females. To analyze the impact of culture, participants were coded as either part of the majority culture (European) or minority (all others). As far as the study's results suggest, the participants' identified culture did not have a significant effect on results of compassion or EI. Regarding the

chosen religion of participants, since 96% chose Christian there was not enough variability to make comparisons of EI, compassion or comfort results based on participants' religion.

Discussion

The current study explored the relationships between EI, and the comfort and compassion felt towards persons with a MI. It was hypothesised that those with higher EI would show higher comfort and compassion. Given that the enhanced understanding of the self is often associated with high EI, it was expected that this would also contribute to a sense of compassion for others and feelings of comfort around people with a MI. It was expected that the understanding of the self would transfer to a willingness to feel compassion for others and a sense of comfort through the familiarity of emotional exploration of the self, which is often associated with MI. There was only limited support for the notion that higher EI predicted higher levels of compassion or comfort toward individuals with MI. This only partially supports the initial hypothesis, and the lack of additional findings will be discussed below.

EI subscales and MIS questions

Minimal evidence was found in support of the prediction that EI would be positively related to MIS cases. The TEIQue-SF explores participant's well-being, self-control, emotionality and sociability (Petrides, 2009). Well-being is defined as a trait that facets happiness, optimism, and self-esteem (Vernon, Villani, Schermer, Kirilovic, Martin, Petrides, Spector, & Cherkas, 2009). High well-being was not significantly related to comfort and compassion with the characters. Self-control refers to emotion control, impulsivity, and stress management. It was expected that high self-control would be related to MIS responses. The expectation was that participants would feel more comfortable engaging with a person with MI given their confidence in controlling their own emotions. Self-control was related to comfort with the characters. Emotionality explores emotion-perception, empathy, emotion expression, and relationships. A participant's ability to perceive their

own emotions was expected to contribute to their ability to empathize with the MIS characters and the emotions associated with their MI. Emotionality was related to compassion felt towards characters. Sociability refers to emotion management, assertiveness, and social awareness. It was expected that the impact of one's own social awareness would influence a participant's view MIS characters and their behaviour under a social context. However, sociability was not significantly related to responses to the case studies. Thus, the current study revealed MIS responses as being weakly positively related to the EI measures of well-being, emotionality, and self-control.

The measurement of well-being was positively related to people's comfort with giving directions to the MIS character. This demonstrates that those with higher levels of well-being are likely to feel more comfortable engaging with a person who has a MI. Perhaps one's feeling of comfort when interacting with a person with a MI is due to the increased satisfaction in one's own life associated with well-being. EI was more important in predicting participant's comfort than their compassion, where higher levels of comfort were associated with higher levels of self-control. It was predicted that higher levels of self-control (EI) would also be higher levels of comfort. Results of self-control showed a positive relationship to participant's comfort with sitting next to and giving directions to the MIS character, and their average level of comfort for the MIS characters. The ability to control one's own emotions through self-control may produce influence confidence that contributes to feeling comfortable around people with a MI. Emotionality was positively related to people's concern for and overall compassion for the MIS characters. It is possible that the acknowledgement of one's own emotions allows for people to feel a relation to others and their emotions, particularly emotions associated with a MI. Finally, overall compassion was positively related to peoples concern for, feelings of compassion for, and the average of compassion questions for the MIS characters. This demonstrates that high levels of comfort for people with a MI also show high levels of compassion in general. Therefore, compassion may not

always be consistent with high comfort. A person's experience with a MI or particular level of EI may mean they feel compassion towards person's with a MI, but may not necessarily feel comfortable interacting with them. Furthermore, those who are most empathetic with a person's distress might be less comfortable because they are sensitive to their own distress.

Personal and Family History of MI

The participants' history of MI was an important factor in the current study. It was hypothesised that a person with a MI would engage in frequent self-reflection and understanding in order to function with their own mental challenges. Thus, it was presumed that they would have high EI levels and feel comfort and compassion for others with a MI as they can relate to them. Results showed that participants with a MI actually showed lower levels of EI and of comfort towards the characters with MI. One reason for this may be participant's personal connections to the characters in the MIS, and associations that are traumatic or triggering that result in discomfort. The participants prior experience with a MI and the associated discomfort with that experience, may have contributed to less comfort with others who have a MI. As well, perhaps the TEIQue-SF measure of well-being showed that people with a MI usually have a lower well-being due to the stress of their MI. Someone who does not have a MI themselves may show a sense of comfort due to their absence of illness, and perhaps an ignorance of the severity of MI and its potentially uncomfortable symptoms. A person with MI may more accurately perceive what another person with MI is experiencing because they can more effectively relate to their situation. Someone without a MI might be more comfortable as they may not accurately perceive the situation.

Regarding MIS comfort and compassion and overall compassion scores for individuals with or without a personal history of MI, the respondents with a personal history of MI demonstrated higher compassion levels in responding to the case studies but did not have higher overall compassion scores. This indicates that some experience with MI might contribute to higher

compassion towards people with MI, but not for compassion in general. This is consistent with the initial prediction, which stated that personal history would contribute to a higher sense of compassion towards others with a MI. A personal history with MI may produce feelings of empathy or relatability towards the MIS characters, which might have contributed to an increase in feelings of compassion towards those individuals. The overall compassion scale does not place particular focus on perception of individuals with MI, which may have played a role in the lack of significance between participants with a MI and the measurement of general compassion.

These results suggest that the complexity that accompanies the mind when facing a MI may make it difficult to enhance one's EI. Given that MI often provides distress in one's emotional state, the energy and focus necessary to establish a high EI may not be as accessible for a person with a MI. This may have contributed to the rejection of the hypothesis that MI would actually contribute to a stronger EI based on the necessity to self-analyze as one navigates the addition of a MI in general life.

Those with MI Family History vs. no MI Family History

The current study hypothesised that having a family member with a MI may provide an enhanced perspective of MI for an individual who does not have a MI. It might be expected that the exposure of symptoms and behaviours shown in forms of MI through a relative would influence a person's comfort or compassion towards all people with MI. In the current study, participants with a family history that provided some experience with MI showed similar levels of comfort and compassion to respondents without a family history of MI. No evidence was found to suggest that having a family member with MI would increase levels of comfort and compassion toward someone with MI. These conclusions could be the result of a number of factors, including the increase in MI research and the societal acceptance of mental health validity providing insight on the details of MI for all people, not just those with a connection to MI. As well, it is possible that

participants may be influenced to explore the possibility of a personal MI through the presence or absence of a MI in a family member. Given the prevalence of MI today, even those folks with no family history of MI could have had close friends with MI and therefore may have had comparable levels of experience with MI to those with a family history of MI.

Conclusions

EI, Compassion and MIS Scale Limitations

Although it was predicted that high EI would contribute to high compassion and comfort in participants as they reflect on the MIS, the study's data suggests that this is not always the case. The particular EI measure used in the current study may have contributed to the outcome. Perhaps the various elements within this EI measure, such as the subscale of well-being, which might be understood as a measure of mental health, may not entirely reflect all that is intended in the concept of emotional intelligence. Furthermore, the types of MI described through the MIS were limited to just depression, obsessive compulsive disorder, schizophrenia, bipolar and anxiety. Although these MI are common, the limited types presented may have limited the participants' ability to relate of the MIS characters, which may have affected their response to the MIS questions.

Although the study did not show strong relationships between EI and responses to the case studies, it did none the less establish a connection between EI and comfort with the types of MI proposed in the MIS. This means that EI does in fact have an effect on how a person perceives others, but the effect was not as strong as the one originally predicted. Further, these results may be specific to these particular stories and characters. Many participants added comments to their responses which specifically noted personal characteristics of a particular case (such as being more uncomfortable 'sitting next to' a male with a MI as opposed to a female with a MI). Future research might benefit from using more detailed and varied case studies to depict MI, or a different method of exposure to MI entirely. The EI measure required participants to intimately evaluate themselves.

Given that EI was measured after the case studies had been presented, the ways the participants responded might have been influenced by the priming of the MIS characters and their relation to them.

The current study shows that EI (based on results of the TEIQue-SF) is not necessarily a reliable source for predicting how an individual will perceive a person with MI. However, certain elements within EI measures such as well-being, self-control or emotionality can help predict a person's level of compassion or comfort towards persons with MI. The current study hypothesised that EI and overall compassion levels would directly predict its participants' levels of compassion and comfort towards people with MI. With results that show EI and compassion levels are factors in the perception of MI, the hypothesised relationship within these factors was partially supported, based particularly on the subscales of EI that were used (well-being, self-control, emotionality and sociability).

The present study provided unexpected results in relation to the initial hypothesis. This means that what is inferred of people and their perceptions of persons with MI may not be as what was predicted. Amongst the most impactful conclusions derived from the study's results is the data showing that a measure of high EI (based on the TEIQue-SF) does not always show a positive correlation to high levels of compassion (as shown though the compassion scale and MIS response results). With particular focus on personal history with MI, the current study revealed that a person with a MI does not necessarily have high EI, and may show low levels of comfort and compassion towards individuals with a MI. Given the restricted measures provided in the short form of the TEIQue (Petrides, 2009) through the TEIQ-SF, it might be beneficial to use various measures of EI to ensure reliable and valid results in future study's.

General Limitations

The results of the current study provide data that only partially supported the initial hypothesis. Although the current study provided interesting data, it did not come without various limitations, such as the limited number of participants and the short range of demographics. The study took place at Tyndale University, and the majority of participants were students from this Christian institution, limiting the variability in religious affiliation of participants. As well, the majority of Tyndale Students were female, which limited the gender variability. Given the motivation of a 1% extra credit in a psychology course upon participation of the study, many participants were also psychology majors. The homogeneity of participants in this sample limits the generalizability of these findings. A larger sample with greater variability is necessary before any large scale generalizations are appropriate. To increase participant variability, it might be helpful to have the study completed through an online survey platform. The current study was completed on specific dates and times, which created a restriction on the participants availability. This would also allow for participants of various demographics to participate through extended accessibly.

Future research on the relationship between the perception of MI and EI might benefit from focusing on particular components of EI. The current study demonstration that the components of well-being, self-control and emotionality and total EI are significant in relation to perceptions of MI. Future studies may conduct research that focus on a specific components, such as the relationship between ones well-being and their perspective of people with a MI, to illuminate the specific factors that support the current study's results.

With particular focus on the category of family history, a larger number of participants might have contributed to more significant results. The direction of the results was still unexpected based on the initial hypothesis, perhaps because MI is often genetic, and the presence of a MI in one's family could mean the presence of a MI in the participant as well. Furthermore, the use of current study's data might help refine research on compassion and MI in the future.

Overall, the study's research suggests that perceptions are based on numerous factors and influences. EI, compassion and comfort are determined by a broad spectrum of factors. More information derived on the reasoning behind strong or weak signs of compassion or comfort may contribute to a healthier, more educated, and overall peaceful future for persons with MI and in general mental health culture. Particularly, information on why certain individuals respond to people with a MI in the manner that they do, may help explain why certain people have a lack of compassion or comfort with people with a MI. Assessing the data of future studies may help to prevent peoples negative or unkind responses to persons displaying a MI. With more information on an individual with factors associated with a negative stigma towards MI, there is potential for preventative measures of their behaviour to be proposed. This is especially true if future research can help identify particular demographic or MI history factors that propose a likelihood of negative perspectives towards MI. Furthermore, the element of self-reflection in participants who engage in future mental health research may increase a sense of empathy for others, as particular characteristics are revealed. There are countless factors that contribute to an individual's perception of others, especially with regards to mental health and MI. The current study proposes the importance of showing compassion in response to persons with MI, and its results encourage further research on the topic of EI and perceptions of MI.

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Appendix A

Informed Consent Form

Psychology Honors Thesis Project

Emotional Intelligence and Perspectives of Mental Health: Comfort and Compassion Towards Individuals with Mental Illness

Principal Investigator: Renée Lehman
Phone Number: 5196157372
Email: renee.lehman0623@gmail.com
Faculty Supervisor: Dr. Nancy Ross
Phone Number: (416) 226- 6620
Email: nross@tyndale.ca

This study has been reviewed and received ethics approval through the REB. For any questions regarding rights of participant please contact the primary investigator; Renée Lehman. For contact to the Research Ethics Review Board: reb@tyndale.ca.

This is an informed consent form created for the thesis project of undergraduate Student Renée Lehman at Tyndale University College & Seminary. The purpose of this research project is to evaluate the relationship between a participant's emotional intelligence (EI) and their perspective of mental illness and mental health conditions. The study will examine its participant's levels of comfort and compassion towards individuals with mental illness. Identifying factors such as the age, gender, occupation, religion, and personal or family history of mental health will vary among participants.

The study will include a booklet of documents containing case studies presenting individuals with a mental illness (MIS), a response questionnaire, an EI test, and a demographic survey. If needed during or after the study, participants will be given the ability to access Tyndale's counselling center safely. Tyndale Students will receive the granted discount for the Counselling services, all other participants will be subject to regular payment. The study will take place in a secure environment, giving the participants the option to stop at any time. Although they will not be eligible to return to their documents, participants may exit the study without consequence. Subjects will not be waiving any legal rights through their participation in the study. They will remain eligible for 1% extra credit and the chance for a 25$ Amazon gift card.

Purpose of the Research

The purpose of this study is to explore the relationship between EI and the variables of comfort and compassion in one's perspective towards individuals with mental illness and mental health conditions. The research will evaluate various identifying factors of a participant (including their EI). Participants will read multiple case studies depicting numerous forms of mental illness stories, followed by a response questionnaire. The results of this study will investigate the comfort and compassion levels of participants towards persons with mental illness, and provide clarity on the relationship with EI.

Type of Research Intervention

The research is a quantitative study, deriving correlational data from participants.

Participant Selection

A variety of participants will be chosen to engage in this study. Individuals varying in factors such as age, gender, occupation, religion, and history of mental health will be participating. The study will investigate various perspectives of life to ensure validity.

Voluntary Participation

Participants will be given freedom of choice whether or not to participate. Students enrolled in a psychology course at Tyndale will be given the option of 1% extra credit for participating in the study. Tyndale students who choose not to engage in the research will have the opportunity to complete an assignment from a participating professor for an alternative 1%.

All participants (including all students at Tyndale University) will be given a chance to win a $25 amazon gift card for their enrolment in the study. The participants may retreat from the study at any point while still receiving the due extra credit and having their entry remain in the draw for the Amazon gift card. The discontinuing of the study after it has begun will involve no penalty or loss of benefits to which the participant is otherwise entitled. The participants will be given a maximum of thirty minutes to complete the documents. There will not be consequences to the eligibility of extra credit or compensation if participants are unable to finish the study in the designated time period. During the session of completing the studies' booklet, participants will be reminded of their access to Tyndale Counselling center. This resource is available due to the sensitivity and intensity delivered through the MIS and EI test, and the risk of any overwhelming thoughts or the occurrence of discomfort.

Procedures

The study will involve a small private room with a neutral environment. Before entering the room, participants will be required to sign this form as a means of consent for the study. The participants' names and student numbers (if applicable) will be recorded using MS excel, and entries will be randomized to ensure confidentiality in a draw for the Amazon gift card. The participant will complete a series of documents in a booklet found on a desk in their designated room. The room will be silent, and the participant will complete their documents alone. The door will be closed but

unlocked, and the participant will be reminded that they may exit at any given time. Participants will be told of the available resources present (mental health counselling center, water, etc.) and where to access them in the duration of the study.

Once completing the booklet, participants will place their documents in an empty basket placed in the corner of the room. This will be collected before the next participant enters the room.

Duration

The participants will be given unlimited time to complete their booklet. The dates and times of the study will be in October 2019. Each day will have three different time slots.

Apparatus

The apparatus used to execute this study will begin with the completion of this informed consent form. Upon entering the room of study, participants will start a booklet of documents. These documents will contain the five case studies depicting individuals facing various types of mental illness, and follow-up response questions.

The booklet will also contain the Trait Emotional Intelligence Questionnaire (TEIQue-SF), the Compassionate Love for Humanity Scale, and an identification survey.

Risks

This study exposes participants to detailed stories of characters experiencing various cases of mental illness. There will be risks of triggering a variety of emotional responses to these stories. There is emotional and personal involvement requested in the completion of the Trait Emotional Intelligence questionnaire, the Compassionate Love for Humanity Scale, and the MIS response questions. These documents will require an evaluation of the self, where the participants may find difficulty given the intensity of the requests.

As mentioned previously, participants have the freedom to withdraw from the study at any point in time, with resources available to provide aid to their distress. The research involves quantitative questions using the format of a Likert scale.

Benefits

In completion of this study, Tyndale student participants enrolled in a Psychology course will be given 1% extra credit. Tyndale students who choose not to participate in the study will have the option to complete an essay from a professor for an alternative 1%. All participants will receive a chance to win a $25 amazon gift card for the contribution to the study. Amongst the specific benefits provided from this study, participants will be actively participating in the awareness and promotion of a more positive and open perspective of mental health within society today.

Research is being conducted on what contributes to a person's perception of mental health in relation to their emotional intelligence. The current study's data may add to methods of promoting comfort and compassion towards individuals who are challenged with their mental health.

Confidentiality

The researcher has taken every account to ensure full confidentiality for participants taking part in this study. The evaluation of the completed survey data will occur in a secured space. The confidentiality of records will be maintained. In rare cases it may not be possible to ensure confidentiality because of mandatory reporting laws (e.g., suspected child abuse; reportable communicable diseases; some community-based research). The data collected through this study may be used in secondary studies and further research on the topics covered. All rights and confidentiality will be honoured in the further use of this data.

- _____ Has read and understood the relevant information
- _____ Understands that he or she may ask questions in the future
- I _____ freely consent to research participation by the signing of this research consent form.
-

Print First Name of Participant: _____
Tyndale Student Number of Participant (if applicable): _____
Signature of Participant: _____

Appendix B

Mental Illness Case Studies and Response Questions:

1. Kim, a university student of Korean descent, was hospitalized after he was found wandering around on the city streets, yelling at strangers because they did not bow when he walked by. Upon questioning, Kim declared that he was the emperor of Korea and that those on the street were not giving him the deference appropriate to his royal status (Beidel, Bulik, Stanley & Taylor, 2018).

A. I would be willing to sit next to Kim in a public place (restaurant, public transit, etc).

Disagree 1 2 3 4 5 6 7 Agree

B. I have concern for Kim and his future comfort in life.

Disagree 1 2 3 4 5 6 7 Agree

C. I would be comfortable giving Kim directions if he approached on the street.

Disagree 1 2 3 4 5 6 7 Agree

D. I have compassion for Kim and his challenges described in the story above.

Disagree 1 2 3 4 5 6 7 Agree

Is there anything you would like to clarify about your reactions to Kim?

: _____

2. When Donny came home from school, he had to take a shower immediately. It would take him about an hour in the shower before he felt clean. If someone or something interrupted his routine, it would take a lot longer-he would have to start again from the beginning. Donny washed his clothes in the washing machine constantly. In the past, year, he had used the machine so extensively that his parents had to twice replace it with a new one (Beidel et al., 2018).

A. I would be willing to sit next to Donny in a public place (restaurant, public transit, etc).

Disagree 1 2 3 4 5 6 7 Agree

B. I have concern for Donny and his future comfort in life.

Disagree 1 2 3 4 5 6 7 Agree

C. I would be comfortable giving Donny directions if he approached me on the street.

Disagree 1 2 3 4 5 6 7 Agree

D. I feel compassion for Donny and his challenges described in the story above.

Disagree 1 2 3 4 5 6 7 Agree

Is there anything you would like to clarify or explain about your reactions to Donny?

: _____

3. Melissa's mother brought her to the clinic because of her constant worry that she is going to die. Although she was 9 years old and in good health, she worries that she might die from getting sick or that she will "choke on phlegm and die." Melissa told the interviewer that she worries that when she gets older she might have a heart attack and die. She also worries that her parents or her brother might die and she will be all alone. She is afraid that her parents might leave home one day, get lost, and "never, ever find their way back and I'll be alone" (Beidel et al., 2018).

A. I would be willing to sit next to Melissa in a public place (restaurant, public transit, etc).

Disagree 1 2 3 4 5 6 7 Agree

B. I have concern for Melissa and her future comfort in life.

Disagree 1 2 3 4 5 6 7 Agree

C. I would be comfortable giving Melissa directions if she approached me on the street.

Disagree 1 2 3 4 5 6 7 Agree

D. I feel compassion for Melissa and her challenges described in the story above.

Disagree 1 2 3 4 5 6 7 Agree

Is there anything you would like to clarify or explain about your reactions to Melissa?

: _____

4. Louise was under a constant grey cloud. She felt that she had lived through the marriage of her daughter and the birth of her first two grandchildren like a zombie. She felt no joy, no wonder, and would rather stay home and cry than visit and play with her grandchildren. When all of the other women at church beamed about the accomplishments of their families, she could only feel guilty for not being part of her own children's lives one (Beidel et al., 2018).

A. I would be willing to sit next to Louise in a public place (restaurant, public transit, etc).

Disagree 1 2 3 4 5 6 7 Agree

B. I have concern for Louise and her future comfort in life.

Disagree 1 2 3 4 5 6 7 Agree

C. I would be comfortable giving Louise directions if she approached me on the street.

Disagree 1 2 3 4 5 6 7 Agree

D. I feel compassion for Louise and her challenges described in the story above.

Disagree 1 2 3 4 5 6 7 Agree

Is there anything you would like to clarify or explain about your reactions to Louise?

: _____

5. Carrie was a second year college student when she first began having in school and stopped going to classes. She started having sexual relationships with 4 different men and she spent all of the money she had for the school year in three months. When her parents discovered the problems, they brought her in for evaluation. Carrie did not feel that anything was wrong. She felt that she had just made several poor decisions, like

anyone her age. Her parents felt things were not the same. She had always been a thoughtful, responsible person prior to the last several months (Beidel et al., 2019).

A. I would be willing to sit next to Carrie in a public place (restaurant, public transit, etc).

Disagree 1 2 3 4 5 6 7 Agree

B. I have concern for Carrie and her future comfort in life.

Disagree 1 2 3 4 5 6 7 Agree

C. I would be comfortable giving Carrie directions if she asked me on the street.

Disagree 1 2 3 4 5 6 7 Agree

D. I have compassion for Carrie and her challenges described in the story above.

Disagree 1 2 3 4 5 6 7 Agree

Is there anything you would like to clarify or explain about your reactions to Kim?

: _____

Questions Designed by: Renée Lehman

Retrieved from:

Beidel, D.C., Bulik, C.M., Stanley, M.A., & Taylor, S. (2018). *Abnormal Psychology*. Don Mills, Ontario: Pearson Canada Inc.

Appendix C

Trait Emotional Intelligence Questionnaire – Short Form (TEIQue-SF)

Instructions: Please answer each statement below by putting a circle around the number that best reflects your degree of agreement or disagreement with that statement. Do not think too long about the exact meaning of the statements. Work quickly and try to answer as accurately as possible. There are no right or wrong answers. There are seven possible responses to each statement ranging from 'Completely Disagree' (number 1) to 'Completely Agree' (number 7).

1 . . . . . 2 . . . . . 3 . . . . . 4 . . . . . 5 . . . . . 6 7
Completely Disagree **Completely Agree**

1. Expressing my emotions with words is not a problem for me.	1	2	3	4	5	6	7
2. I often find it difficult to see things from another person's viewpoint.	1	2	3	4	5	6	7
3. On the whole, I'm a highly motivated person.	1	2	3	4	5	6	7
4. I usually find it difficult to regulate my emotions.	1	2	3	4	5	6	7
5. I generally don't find life enjoyable.	1	2	3	4	5	6	7
6. I can deal effectively with people.	1	2	3	4	5	6	7
7. I tend to change my mind frequently.	1	2	3	4	5	6	7
8. Many times, I can't figure out what emotion I'm feeling.	1	2	3	4	5	6	7
9. I feel that I have a number of good qualities.	1	2	3	4	5	6	7
10. I often find it difficult to stand up for my rights.	1	2	3	4	5	6	7
11. I'm usually able to influence the way other people feel.	1	2	3	4	5	6	7
12. On the whole, I have a gloomy perspective on most things.	1	2	3	4	5	6	7
13. Those close to me often complain that I don't treat them right.	1	2	3	4	5	6	7
14. I often find it difficult to adjust my life according to the circumstances.	1	2	3	4	5	6	7
15. On the whole, I'm able to deal with stress.	1	2	3	4	5	6	7
16. I often find it difficult to show my affection to those close to me.	1	2	3	4	5	6	7
17. I'm normally able to "get into someone's shoes" and experience their emotions.	1	2	3	4	5	6	7
18. I normally find it difficult to keep myself motivated.	1	2	3	4	5	6	7
19. I'm usually able to find ways to control my emotions when I want to.	1	2	3	4	5	6	7
20. On the whole, I'm pleased with my life.	1	2	3	4	5	6	7
21. I would describe myself as a good negotiator.	1	2	3	4	5	6	7
22. I tend to get involved in things I later wish I could get out of.	1	2	3	4	5	6	7
23. I often pause and think about my feelings.	1	2	3	4	5	6	7

24. I believe I'm full of personal strengths.	1	2	3	4	5	6	7
25. I tend to "back down" even if I know I'm right.	1	2	3	4	5	6	7
26. I don't seem to have any power at all over other people's feelings.	1	2	3	4	5	6	7
27. I generally believe that things will work out fine in my life.	1	2	3	4	5	6	7
28. I find it difficult to bond well even with those close to me.	1	2	3	4	5	6	7
29. Generally, I'm able to adapt to new environments.	1	2	3	4	5	6	7
30. Others admire me for being relaxed.	1	2	3	4	5	6	7

Trait Emotional Intelligence Questionnaire – Short Form (TEIQue-SF). This 30-item form includes two items from each of the 15 facets of the TEIQue. Items were selected primarily on the basis of their correlations with the corresponding total facet scores, which ensured broad coverage of the sampling domain of the construct. The –SF can be used in research designs with limited experimental time or wherein trait EI is a peripheral variable. Although it is possible to derive from it scores on the four trait EI factors, in addition to the global score, these tend to have somewhat lower internal consistencies than in the full form of the inventory. The –SF does not yield scores on the 15 trait EI facets.

Scoring information for the TEIQue-SF is available at: http://www.psychometriclab.com/Home/Default/14 Please note that we cannot provide any advice on how to run the syntax in SPSS or other statistical software.

Please make sure you read the FAQ section at http://www.psychometriclab.com/Home/Default/18. In particular, note that we do not provide free information regarding norms or free feedback reports. Norms and reports are available for a fee (email admin@teique.com for quotes).

Reference for the TEIQue-SF: Petrides, K. V. (2009). Psychometric properties of the Trait Emotional Intelligence Questionnaire. In C. Stough, D. H. Saklofske, and J. D. Parker, *Advances in the assessment of emotional intelligence*. New York: Springer. DOI: 10.1007/978-0-387-88370-0_5

For more information about the trait emotional intelligence research program go to: www.psychometriclab.com

Appendix D

Compassionate Love for Humanity Scale

Description of Measure:

A 21-item measured designed to measure compassionate love for humanity. Compassionate love toward humanity is defined as an attitude toward humanity that involves behavior, feeling, and thinking that focuses on concern, caring, and support for humanity, as well as a motivation to understand and help humanity (strangers) when they are most in need. And, "humanity" is considered anyone who is a stranger (not a close other). Respondents answer each item on a 7-point

Likert-type scale ranging from 1 (not at all true of me) to 7 (very true of me).

Scale

1.) When I see people I do not know feeling sad, I feel a need to reach out to them.

not at all true of me 1 2 3 4 5 6 7 very true of me

2.) I spend a lot of time concerned about the well-being of humankind.

not at all true of me 1 2 3 4 5 6 7 very true of me

3.) When I hear about someone (a stranger) going through a difficult time, I feel a great deal of compassion for him or her.

not at all true of me 1 2 3 4 5 6 7 very true of me

4.) It is easy for me to feel the pain (and joy) experienced by others, even though I do not know them.

not at all true of me 1 2 3 4 5 6 7 very true of me

5.) If I encounter a stranger who needs help, I would do almost anything I could to help him or her.

not at all true of me 1 2 3 4 5 6 7 very true of me

6.) I feel considerable compassionate love for people from everywhere.

not at all true of me 1 2 3 4 5 6 7 very true of me

7.) I would rather suffer myself than see someone else (a stranger) suffer.

not at all true of me 1 2 3 4 5 6 7 very true of me

8.) If given the opportunity, I am willing to sacrifice in order to let the people from other places who are less fortunate achieve their goals.

not at all true of me 1 2 3 4 5 6 7 very true of me

9.) I tend to feel compassion for people even though I do not know them.

not at all true of me 1 2 3 4 5 6 7 very true of me

10.) One of the activities that provides me with the most meaning to my life is helping others in the world who need help.

not at all true of me 1 2 3 4 5 6 7 very true of me

11.) I would rather engage in actions that help others, even though they are strangers, than engage in actions that would help me.

not at all true of me 1 2 3 4 5 6 7 very true of me

12.) I often have tender feelings toward people (strangers) when they seem to be in need.

not at all true of me 1 2 3 4 5 6 7 very true of me

13.) I feel a selfless caring for most of mankind.

not at all true of me 1 2 3 4 5 6 7 very true of me

14.) I accept others whom I do not know even when they do things I think are wrong.

not at all true of me 1 2 3 4 5 6 7 very true of me

15.) If a person (a stranger) is troubled, I usually feel extreme tenderness and caring.

not at all true of me 1 2 3 4 5 6 7 very true of me

16.) I try to understand rather than judge people who are strangers to me.

not at all true of me 1 2 3 4 5 6 7 very true of me

17.) I try to put myself in a stranger's shoes when he or she is in trouble.

not at all true of me 1 2 3 4 5 6 7 very true of me

18.) I feel happy when I see that others (strangers) are happy.

not at all true of me 1 2 3 4 5 6 7 very true of me

19.) Those whom I encounter through work and public life can assume that I will be there for them if they need me.

not at all true of me 1 2 3 4 5 6 7 very true of me

20.) I want to spend time with people I don't know well so that I can help enrich their lives.

not at all true of me 1 2 3 4 5 6 7 very true of me

21.) I very much wish to be kind and good to fellow human beings.

not at all true of me 1 2 3 4 5 6 7 very true of me

Scoring: An average score is calculated for all 21 items. Scoring is kept continuous.

Appendix E

Demographic Survey

Please circle the answer that best pertains to you

What is your gender?

- O Male
- O Female
- O Unidentified
- O Other (please specify) _____

What is your Age?

- O 18 - 25
- O 26 - 35
- O 36 – 59
- O 60+

What is your religious affiliation or belief system? (check all that apply)

- O Christianity
- O Islam
- O Catholicism
- O Judaism
- O Atheism
- O Hinduism
- O Buddhism
- O Agnosticism
- O Other (please specify) _____
- O N/A

What is your race/ethnicity? (check all that apply)

- O North American
- O North American Aboriginal
- O European
- O Caribbean
- O Latin, Central or South American

- O Asian
- O Oceania
- O Other (please specify) _____

What is your occupation status? (check all that apply)

- O Full time student
- O Part time Student
- O Full time profession/job
- O Half time profession/job
- O Retired
- O Other (please specify) _____

Personal History of Mental Health Conditions

- O Diagnosed with a mental illness as of 2+ years ago
- O Recently diagnosed mental illness within 1 year
- O No known personal history of mental illness
- O Current or past suspected but undiagnosed mental illness

If yes to question above, how long has this been suspected? _____

- O Other (Please Specify)_____

History of Mental Illness in Family (check all that apply)

Immediate Family: spouse, siblings, children or parents.

Extended Family: grandparents, aunts, uncles, cousins.

- O No history of mental illness in immediate or extended family
- O Diagnosed mental illness in immediate family members
- O Suspected but undiagnosed mental illness in immediate family members
- O Diagnosed mental illness in extended family members
- O Suspected but undiagnosed mental illness in extended family members
- O Unsure of history of mental illness in family members

Is there any other information you'd like to comment on regarding your experience with mental health? (Ex. friends with mental health conditions, other history not mentioned, etc.)

On behalf of the researcher, thank you very much for your contribution to this thesis study. The data you have provided may play a role in furthering a more positive and accepting understanding of mental illness within society today. May God Bless you and your future endeavours.

With deepest appreciation and gratitude,
Renée Lehman.

Appendix F
Matrix scatterplots of the relationships between EI subscales and MIS comfort and compassion

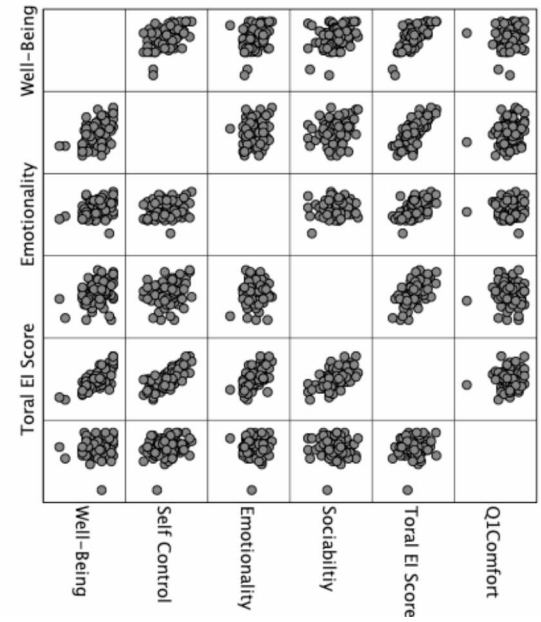

Figure 1: Matrix scatterplot of the relatonships between each EI measure and MIS question 1

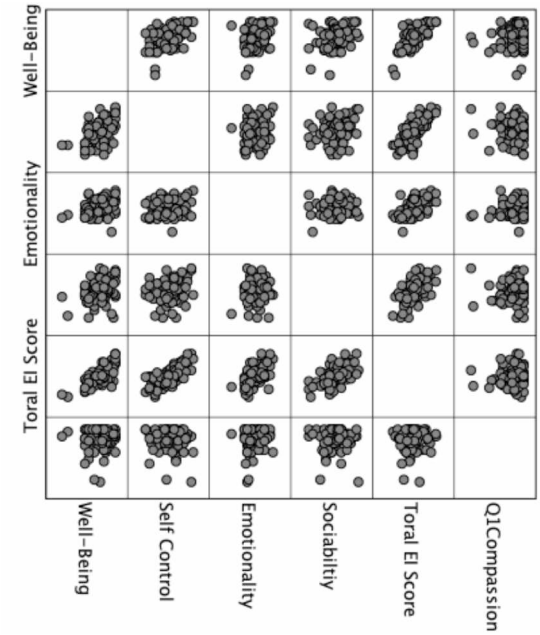

Figure 2: Matrix scatterplot of the relatonships between each EI measure and MIS question 2

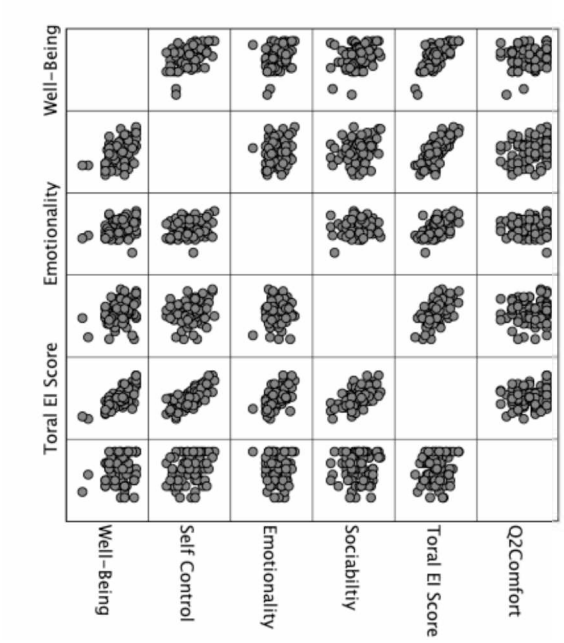

Figure 3: Matrix scatterplot of the relatonships between each EI measure and MIS question 3

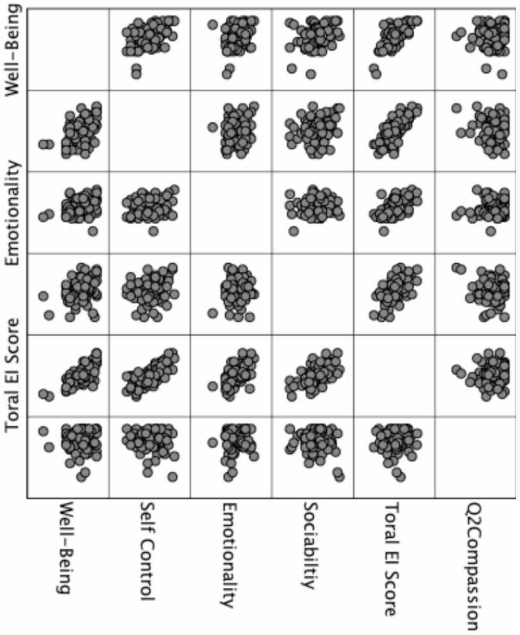

Figure 4: Matrix scatterplot of the relatonships between each EI measure and MIS question 4

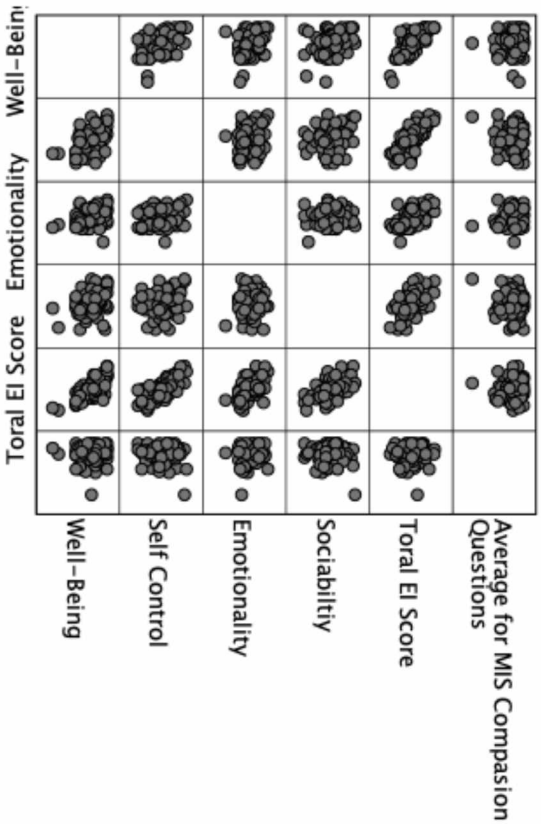

Figure 6: Matrix scatterplot of the relatonships between each EI measure and MIS compassion

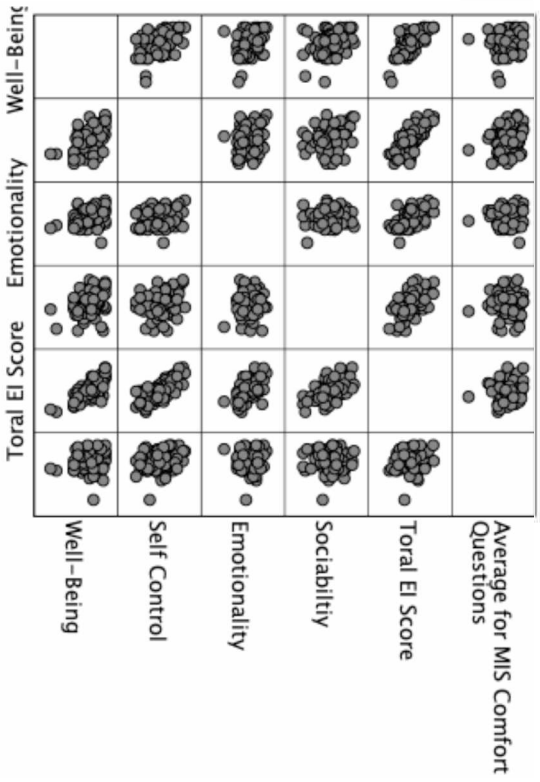

Figure 5: Matrix scatterplot of the relatonships between each EI measure and MIS comfort