

2018

# THE ROLE OF BIPOLAR DISORDER, STIGMA, AND HURTFUL MESSAGES IN ROMANTIC RELATIONSHIPS

Callie Parrish

*University of Montana, Missoula*

Let us know how access to this document benefits you.

Follow this and additional works at: <https://scholarworks.umt.edu/etd>

 Part of the [Interpersonal and Small Group Communication Commons](#)

---

## Recommended Citation

Parrish, Callie, "THE ROLE OF BIPOLAR DISORDER, STIGMA, AND HURTFUL MESSAGES IN ROMANTIC RELATIONSHIPS" (2018). *Graduate Student Theses, Dissertations, & Professional Papers*. 11129.  
<https://scholarworks.umt.edu/etd/11129>

This Thesis is brought to you for free and open access by the Graduate School at ScholarWorks at University of Montana. It has been accepted for inclusion in Graduate Student Theses, Dissertations, & Professional Papers by an authorized administrator of ScholarWorks at University of Montana. For more information, please contact [scholarworks@mso.umt.edu](mailto:scholarworks@mso.umt.edu).

THE ROLE OF BIPOLAR DISORDER, STIGMA, AND HURTFUL MESSAGES IN  
ROMANTIC RELATIONSHIPS

By

CALLIE ROSE PARRISH

Bachelor of Arts, University of Wyoming, Laramie, Wyoming, 2016

Thesis

presented in partial fulfillment of the requirements  
for the degree of

Master of Arts  
in Communication Studies

The University of Montana  
Missoula, MT

May 2018

Approved by:

Scott Whittenburg, Dean of The Graduate School  
Graduate School

Dr. Christina Yoshimura, Chair  
Communication Studies

Dr. Stephen Yoshimura  
Communication Studies

Dr. Craig McFarland  
Clinical Neuropsychology

## The Role of Bipolar Disorder, Stigma, and Hurtful Messages in Romantic Relationships

Chairperson: Dr. Christina Yoshimura

This study explores hurtful messages received by individuals diagnosed with bipolar disorder I/II from their romantic partners. Close romantic relationships present opportunities for the utterance of hurtful messages, and the stigmatization that accompanies a mental health diagnosis could affect the attributions made surrounding hurtful messages. By applying attribution theory, the current study increases understanding of how individuals with bipolar disorder experience and attribute hurtful messages. Participants ( $N = 99$ ) were adults diagnosed with bipolar disorder who had received a hurtful message from their romantic partner. Data was collected via online surveys comprised of Likert scales and short answer questions. Five hurtful message types emerged: *assessment*, *admonition*, *rejection*, *minimization*, and *miscellaneous*. Participants reported a significant positive relationship between self-stigma harm and context-specific attribution ( $r = .263, p < .01$ ). Additionally, a significant positive relationship between context-specific attributions and hurtful message severity emerged ( $r = .273, p < .01$ ). Results of this study enhance current knowledge about how individuals make context-specific attributions for hurtful messages they receive from a romantic partner, offer a focus specifically on the experience of romantic relationships for individuals with bipolar disorder, and offer various theoretical and practical implications.

## Acknowledgements

I would first like to extend endless gratitude to my advisor, Dr. Christina Yoshimura. Thank you for providing your extensive knowledge and expertise in my area of study, for discussing my personal and professional endeavors when I regularly occupied your office, and for your kind attention. Additionally, thank you to Dr. Stephen Yoshimura for providing insight, not only about my thesis (usually in the form of panicked last-minute questions), but also having involved discussions with me about academic life and research. Dr. Craig McFarland, thank you for donating your time and specialized knowledge to this project.

Next, I would like to thank my incredible network of friends, near and far, for offering limitless support throughout this process. They may never realize that by regularly checking in on my mental health and wellbeing, they were in fact sustaining it. I could not have completed this step of my career, especially with intact sanity, without their instrumental and emotional support.

Finally, I would be remiss not to acknowledge the various ways my family has helped me reach this point. Although they would prefer not to take the credit, I am who I am, and where I am, because of them.

## Table of Contents

Introduction.....	1
Literature Review .....	2
Hurtful Messages .....	2
Bipolar Disorder and Stigma .....	3
Attribution Theory .....	6
Hypotheses and Research Questions .....	10
Methods .....	11
Participants.....	11
Measures .....	12
Procedure .....	13
Analysis.....	14
Results.....	15
Types of Hurtful Messages (RQ <sub>1</sub> ).....	15
Hurtful Message Severity (H <sub>1</sub> ).....	16
Self-stigma and Attribution (H <sub>2</sub> ).....	17
Message Severity, Attribution, and Self-stigma (H <sub>3</sub> ) .....	17
Discussion.....	18
Hurtful Messages .....	18
Self-stigma and Context-specific Attributions.....	20
Theoretical Implications .....	21
Practical Implications.....	23
Limitations and Future Research .....	25
Conclusion .....	26
Tables.....	32
Appendix A.....	37
Questionnaire .....	37

## **Introduction**

Hurtful messages are those that convey a sense of devaluation and rejection, and may be especially harmful if they concern an unchangeable characteristic about a person, such as a mental health diagnosis. Hurtful messages vary in severity due to several factors, though they can be particularly harmful in close relationships, such as the relationship between romantic partners (Feeney, 2004; Rittenour & Koenig Kellas, 2015; Vangelisti, 1994). Attribution theory (e.g., Heider, 1958) explains how people make attributions in response to experiences, such as receiving a hurtful message. Attributions help us to make sense of interactions and form expectations about future events (Harvey & Martinko, 2010; Manusov & Spitzberg, 2008; Weiner, 1985). This study will offer insights into the specific kinds of hurtful messages that are communicated between romantic partners when the receiver has a mental health diagnosis, and the attributions made by the receiver.

Mental health disorders have traditionally been considered stigmatic, and individuals belonging to stigmatized groups are usually aware of their stigmatization (Corrigan & Watson, 2002; Hinshaw, 2005). Internalized stigma is particularly useful to study in the context of mental health disorders and romantic relationships because mental health disorders are often invisible, as opposed to many physical illnesses (Weiner, Perry, & Magnusson, 1988). This study will examine whether the attribution patterns of hurtful messages will be affected by a receiver's degree of internalized stigma.

One mental health disorder that is particularly consequential to communication in romantic relationships is Bipolar Disorder. Affecting just over 2% of the U.S. population, bipolar disorder is characterized by interpersonal and communicative challenges due to an individual's persistent cycling between manic and depressive phases (American Psychiatric Association,

2013; NAMI, 2017). The combination of these phases affects communication patterns by creating inconsistency and uncertainty in relational communication, thereby also potentially affecting stress and attribution-making between romantic partners.

This study will further knowledge in health and interpersonal communication in several ways. First, hurtful messages occur in romantic relationships. When people encounter negative experiences, such as hurtful messages, they make attributions surrounding the message. Stigma could affect the reception of and attributions for hurtful messages, because stigmatized individuals are likely aware of the cultural stereotypes surrounding them and will apply them as they receive the hurtful message. Second, bipolar disorder is a traditionally stigmatized diagnosis that is particularly relevant to the study of interpersonal communication because of its ongoing impact on diagnosed individuals' interpersonal functioning. Finally, results of this study will offer strong practical implications for families and romantic partners of an individual with a mental health diagnosis who are hoping to improve communication and avoid hurt in their close relationships.

## **Literature Review**

### **Hurtful Messages**

Vangelisti (1994) defines hurtful messages as conveying a sense of devaluation toward another person (Feeney, 2004; Rittenour & Koenig Kellas, 2015). Vangelisti (1994) identifies 10 types of hurtful messages; most frequently reported messages include accusation (“a charge of fault or offense”), evaluation (“a description of value, worth, or quality”), expression of desire (“a statement of preference”), and information (“a disclosure of information”) (p. 61). Additional hurtful messages reported less frequently are questions, threats, jokes, and lies (Rittenour & Koenig Kellas, 2015; Vangelisti, 1994). Vangelisti (1994) notes certain findings specific to

romantic relationships. For instance, messages about the relationship are considered more complicated and less controllable than messages about non-relational issues. Additionally, informative statements are considered the most hurtful message type; for other messages, the receiver can attempt to defend themselves by offering an excuse or justification, which is more difficult when presented with statements of fact.

Hurtful messages can vary in significance depending on the type of relationship between two people (Feeney, 2004; Vangelisti, 1994). Because people expect their romantic partners to treat them in positive ways, when people receive a hurtful message from a romantic partner they are likely to either make an excuse or reason for the person's behavior or to decide that the message was not intentional (Feeney, 2004; Vangelisti, 1994). However, while certain variables help to cushion the negative impact of hurtful messages, due to the closeness and importance of these relationships, romantic partners have the power to deliver some of the most hurtful messages that individuals experience (Rittenour & Koenig-Kellas, 2015; Vangelisti, 1994; Young, 2004).

### **Bipolar Disorder and Stigma**

Hurtful messages, of varying severity, take place in all romantic relationships. However, evidence suggests that the way these messages are experienced in romantic relationships by someone with bipolar disorder is unique for two reasons. First, bipolar disorder is marked by symptoms that affect communicative and relational functioning. The primary characteristics of bipolar disorder are switches between manic and depressive episodes. Specifically, manic episodes typically consist of: persistent irritable mood with high energy and activity levels, high self-esteem, reduced restful sleep, increased talkativeness, racing thoughts, trouble paying attention, interest in goal-directed activities, and risk-taking behaviors (American Psychiatric



Association, 2013). Hypomania is similar to mania, though functioning is less impaired with hypomanic episodes because it is not characterized by psychotic episodes and allows for higher levels of functioning (American Psychiatric Association, 2013; NIMH, 2017). Alternatively, depressive episodes consist of depressed mood (e.g., sadness or hopelessness), disinterest in activities, significant weight fluctuations, insomnia or fatigue, inability to concentrate, and suicidal ideation or thoughts of death (American Psychiatric Association, 2013).

During manic episodes, individuals tend to alter their communication through increased rapidity of speech, increased use of jokes and theatrics, or complaints and hostility (American Psychiatric Association, 2013). According to Hlastala and Frank (2006), individuals with bipolar disorder face various interpersonal challenges, such as dissatisfaction in romantic relationships, and irritability during both manic and depressive episodes, which can negatively affect partners and relationships. Additionally, individuals with bipolar disorder tend to fluctuate between criticizing their romantic partners or placing them on a pedestal (Hlastala & Frank, 2006). These relationship behaviors potentially increase the risk of conflict or termination within close relationships (Hlastala & Frank, 2006). Additionally, individuals with bipolar disorder are at higher risk for other potentially harmful co-occurring states and behaviors such as psychotic episodes, anxiety, and substance abuse; each of which can further negatively affect personal relationships (NIMH, 2017).

A second reason that the way hurtful messages are experienced in romantic relationships by someone with bipolar disorder is unique from other romantic relationship types concerns the level of stigma ascribed to bipolar disorder in our society, and the way that internalization of that stigma may impact reaction to messages from partners. Stigma results from traits or characteristics about a person that are considered deviant in society (Hinshaw, 2005; Wiener,

Perry, & Magnusson, 1988). Four dimensions contribute to the extent of stigmatization: concealability (e.g., visible or hidden), chronicity (e.g., a permanent or temporary condition), threat or peril (e.g., degree of danger imposed on others), and controllability (e.g., whether a trait is more or less manageable; Hinshaw, 2005). The perception of burden and other stigma surrounding mental health diagnoses has sparked literature concerning how stigma may be internalized, as well as how feelings of stigmatization are transferred to others in close relationships.

Stigmatized individuals tend to be aware of societal stereotypes. When they internalize perceptions of stigma, self-stigmatization occurs (Corrigan & Watson, 2002; Hinshaw, 2005). Internalized stigma, or self-stigma, occurs when individuals assume “stigmatizing assumptions and stereotypes about mental [health diagnoses] and come to believe and apply them to [themselves],” (Drapalski et al., 2013, p. 264). Corrigan and Watson (2002) developed a model showcasing how self-stigma operates in individuals with mental health diagnoses. Individuals who face stigmatization enter a “paradox” (p. 35) between reacting with lower self-esteem, indifference, or righteous anger, depending on whether or not they perceive stigmatized messages as legitimate or warranted (Corrigan & Watson, 2002). This model explains the various conditions under which individuals with mental health diagnoses face feelings of low self-esteem, righteous anger, or indifference. While righteous anger and indifferent reactions may protect individuals from self-stigmatizing, individuals who receive and accept negative messages from society are at greater risk for self-stigmatization, leading to lower self-esteem and self-efficacy. However, as Corrigan and Watson (2002) and Kilk (2015) noted, self-stigmatization can be minimized if an individual rejects the legitimacy of negative messages, or if they have various forms of social support. A unique issue is then presented if a romantic

partner, as a sender of a hurtful message, also serves as a social support figure, which could affect both the severity of the hurtful message, and the level of internalized stigma. Additionally, given the extreme closeness characterized by family and romantic relationships (Crowe & Lyness, 2014), individuals with mental health diagnoses are likely somewhat aware of the supposed associative burden placed on family and romantic partners, which could affect how they experience hurtful messages in those relationships.

Because of the stigmatic nature of bipolar disorder (imposed by others and the self), as well as the symptoms of bipolar disorder, diagnosed individuals may be particularly vulnerable to criticism and other hurtful messages from romantic partners. Further, since personal attitudes about stigma are situational and context-specific (Corrigan & Watson, 2002), hurtful messages from romantic partners may be more severe than the same message in a less significant relationship. These factors may influence the types of attributions individuals with bipolar disorder make regarding hurtful messages in their romantic relationships.

### **Attribution Theory**

Attribution Theory (e.g., Heider, 1958) describes how individuals make sense of everyday interactions (see Harvey & Martinko, 2010; Manusov & Spitzberg, 2008; Weiner, 1985). Heider (1958) explored how individuals act as naïve scientists to organize their world, which helps them to interpret possible causes and reasoning behind various social interactions (Manusov & Spitzberg, 2008). Overall, attributions assist individuals in evaluating personal behaviors and the behaviors of others, not only making sense of past interactions, but generating expectations for future encounters (Manusov & Spitzberg, 2008). Thus, attributions enable individuals to attempt to control or influence future interactions and reach desired responses, while avoiding less desirable responses (Heider, 1958).

Attribution theory typically consists of three causal dimensions: *locus of causality*, *stability*, and *controllability* (Weiner, 1958). First, *locus of causality* describes whether a behavior may be attributed internally and externally (Bauerle, Amirkhan, & Hupka, 2002). Internal causes represent a person's personality traits or general disposition, while characteristics outside of the individual, such as environmental factors, represent external causes (Bradbury & Fincham, 1990; Manusov & Spitzberg, 2008). Second, *stability* describes whether a behavior is considered constant or inconstant (Bauerle et al., 2002; Weiner, 1985). Stable behaviors occur consistently over a period of time and are difficult to change (Harvey & Martinko, 2010). Finally, the degree of influence individuals possess over a given behavior influences their attributions of *controllability* over an event (Bauerle et al., 2002; Manusov & Spitzberg, 2008; Weiner, 1985). Taken together, locus of causality, stability, and controllability have traditionally helped individuals make sense of past events and anticipate future events. These variables are combined in somewhat predictable ways in attributional patterns, such as the self-serving bias, wherein individuals tend to attribute positive experiences internally, and attribute negative experiences externally (Kelley & Michela, 1980). While these dimensions have been combined to explain general attributional processes and patterns, attributions concerning hurtful messages and bipolar stigma may benefit from examination within a context-specific approach.

Recently, Backer-Fulghum, Anders, and Sanford (2016) asserted that while schematic-level assessments of events are useful in measuring a person's general attributional patterns, their attributions may be immediately and variably affected by situational factors. For example, a person's attributional tendencies regarding a romantic partner do not necessarily remain consistent in every conflict with that partner. Backer-Fulghum and colleagues (2016) examined variable attributions and offered an instrument allowing for context-specific attributions of

negative events. The authors explained, "...a context-specific assessment pertains to the cognitive appraisals a person makes about his or her partner in regard to a single, specific episode of relationship conflict" (Backer-Fulghum et al., 2016, p. 1). From this perspective, individuals may make assessments based on one certain behavior (e.g., hurtful outcome of a message) from their romantic partner. According to the authors, responsibility/blame attributions range on a scale from blame (the partner was entirely unwarranted in making a negative statement) to exoneration (the message was legitimate and the partner was entirely warranted in making a negative statement; Backer-Fulghum et al., 2016). Thus, negative attributions impart higher levels of blame or responsibility on the partner for their negative message, while positive attributions yield lower levels of responsibility/blame for their negative message, exonerating the partner or deeming their behavior legitimate (Backer-Fulghum et al., 2016).

Backer-Fulghum et al. (2016) offer a rationale for the use of context-specific attributions when an end goal of research is to identify couple-level interventions. In addition to this anticipated end result of the present study, context-specific attributions are further applicable for use here due to fluctuations in functioning inherent in Bipolar Disorder. Those diagnosed with bipolar disorder are less consistent in mood, cognitive interpretations, and interpersonal functioning than non-diagnosed individuals. Given these symptoms of bipolar disorder, assessing for a "general" pattern of attributions is anticipated to be less helpful than assessing the specific attribution made by the individual in the context of the hurtful message. Thus, a context-specific approach to attributions regarding hurtful messages will be utilized.

Previous research has examined attributions and stigma from various perspectives, such as how individuals associated with a person with a stigmatized trait make attributions for that person's behavior (Weiner, Perry, & Magnusson, 1988), or how causal attributions contribute to

a person's internalization of stigma (Mak & Wu, 2006). Hahlweg (2005) explored attributions people make about high and low expressed emotion (EE) messages from psychiatric patients, hypothesizing that more anger would be related to lower attributed controllability, and more pity would be related to less controllable, external behaviors. Corrigan and Watson (2002) explained that when stigmatized individuals make internal attributions for undesirable behaviors, and external attributions for desirable behavior, self-esteem is diminished. Additionally, Hinshaw (2005) explained,

Given their irrational and at times threatening nature, the behaviors that constitute serious mental disorder tend to be universally stigmatized. Stigma is likely to be fueled by traits and conditions that are believed to be stable, threatening, and controllable, attributes often ascribed to mental disorder (p. 718).

While Corrigan and Watson (2002) offered insights into how attributions affect the self-esteem of people diagnosed with bipolar disorder, less is known about how self-stigmatization affects attributions for messages they receive from others, especially a romantic partner. Though researchers have investigated attributions individuals with mental health diagnoses make about themselves when negative feedback occurs (e.g., Weiner et al., 1988), more research is needed exploring the complexity of stigma and how stigmatized individuals make attributions for the hurtful messages received from others.

Following findings of stigmatic traits of mental illness, Hahlweg (2005) explained that longer illness and older age lead to stronger attributions of stability and controllability. However, little is known about the attributions made by individuals who are diagnosed with a stigmatized mental health disorder when they receive negative feedback from close relational partners. While

individuals tend to make attributions *about* an individual with a mental health diagnosis, more research is needed determining attributions diagnosed individuals *themselves* make.

### **Hypotheses and Research Questions**

The current study asserts that although hurtful messages occur in most interpersonal relationships, hurtful messages about a person's bipolar diagnosis from a romantic partner will be particularly affected by the type of hurtful message shared, the level of receiver's self-stigmatization, and the receiver's context-specific attributions regarding the hurtful message. Reflecting Vangelisti's (1994) work on variation in hurtful message type the first research question and hypothesis are aimed at identifying the particular types of messages most often received about bipolar disorder, and determining whether hurtful messages in this context follow the variation in hurtfulness severity established in previous research.

**RQ<sub>1</sub>:** What types of hurtful messages do individuals with bipolar disorder receive from their romantic partners about bipolar disorder?

**H<sub>1</sub>:** Types of hurtful messages will vary in perceived severity.

The second two hypotheses emerge from Corrigan and Watson's (2002) work on message legitimacy and stigma, as well as Backer-Fulghum et al.'s (2016) suggestion for the use of context-specific attributions regarding relational partners' level blame or exoneration for sharing negative messages.

**H<sub>2</sub>:** Self-stigma scores will be negatively related to responsibility/blame attributions of hurtful messages from romantic partners.

**H<sub>3</sub>:** Hurtful message severity will vary by the diagnosed partner's level of responsibility/blame attributions and self-stigma scores.

## Methods

This study examined communication between individuals with bipolar disorder and their romantic partners; specifically, what hurtful messages individuals with bipolar disorder I/II have received from their romantic partners, and how they account for those messages based on their level of self-stigma and their context-specific attributions. Methods were largely adapted from Rittenour and Koenig Kellas' (2015) work examining hurtful messages and attributions between daughters-in-law and mothers-in-law.

### Participants

Participants ( $N = 99$ ) were adults with ages ranging from 18 to 85 ( $M = 32.18$ ,  $SD = 10.51$ ). Seventy-three (73.7%) participants were female, 23 (23.2%) were male, and 3 (3.0%) indicated their gender as “other.” Ethnicities included: Caucasian/White ( $n = 70$ , 63.1%), African American/Black ( $n = 11$ , 9.9%), Asian/Pacific Islander ( $n = 11$ , 9.9%), Hispanic/Latinx ( $n = 12$ , 10.8%), Native American ( $n = 3$ , 2.7%), other ( $n = 3$ , 2.7%), and Middle Eastern ( $n = 1$ , .9%). Education levels varied, from highest degree earned as a high school diploma/GED ( $n = 22$ , 22.2%), to an associates/vocational/technical degree ( $n = 17$ , 17.2%), to a baccalaureate degree ( $n = 31$ , 31.3%), to a master's degree ( $n = 19$ , 19.2%), and finally to a doctoral degree ( $n = 5$ , 5.1%); with few reports of “other” education ( $n = 5$ , 5.0%).

Participants also reported information concerning their sexual orientation, diagnosis and relational history. Sexual orientation of participants was reported as: 78 (78.8%) heterosexual, 11 (11.1%) bisexual, 5 (5.1%) “other,” 4 (4.0%) lesbian, and 1 (1.0%) gay. Forty-five (45.4%) participants were in a committed relationship, 30 (30.3%) were in a domestic partnership/married, 11 (11.1%) were single, 9 (9.1%) were casually dating, 3 (3.0%) were separated/divorced, and 1 (1.0%) reported their relational status as ‘other.’ Participants had been



in their indicated relationship status for a range of 0-336 months ( $M = 50.30$ ,  $SD = 63.86$ ). Sixty-three (63.6%) participants received their bipolar diagnosis before their relationship began. The 36 (36.4%) individuals who were diagnosed during their relationship were committed to their relational partner before diagnosis for a range of 0-300 months ( $M = 56.39$ ,  $SD = 70.28$ ). Ninety-four (94.9%) had their partner aware of bipolar diagnosis, and 5 (5.1%) indicated that their partner was unaware. Because of the study's inclusion criteria 99 (100%) participants were diagnosed by a mental health professional.

## Measures

This study gathered data via an online survey (Qualtrics.com) comprised of scales and short answer questions measuring hurtful messages, attributions, and self-stigma. The following scales were implemented:

**Hurtful messages.** Participants were first asked, "Think of a time when your partner said something about your bipolar diagnosis that hurt your feelings. In as much detail as possible, please describe your partner's hurtful message in the space below."

**Perceived hurtfulness of the message.** Next, participants indicated their perceived degree of hurt from the message (adapted from Vangelisti, 1994). The scale measured how hurtful the message was on a Likert scale (1 = not at all hurtful, 7 = extremely hurtful).

**Context-specific attributions.** Participants then completed the Context-Specific Attribution Scale, which measures levels of responsibility/blame attributed to partners in context-specific transgressions (Backer-Fulghum et al., 2016). This measure consists of seven items rated on a Likert scale (1 = strongly disagree, 7 = strongly agree). Specifically, three items measure whether the partner is believed to be at fault for the negative impact of the message, and three reversed-scored items measure whether a partner's behavior in sharing the message is exonerated

or considered valid. This scale's language was modified to reflect the hurtful messages context, and showed prior reliability ( $\alpha = .84$ ), and maintained reliability in this study ( $\alpha = .80$ ).

**Self-stigma of mental illness scale- Short form.** Finally, participants completed the Self-Stigma of Mental Illness Scale (SSMIS-SF; Corrigan, Michaels, Vega, Gause, Watson, & Rüschi, 2012), which measures degree of self-stigmatization on four subscale dimensions. The dimensions include: *stereotype awareness (aware*; e.g., “I think the public believes most persons with mental illness are unpredictable”), *stereotype agreement (agree*; e.g., “I think most persons with mental illness are unpredictable”), *stereotype self-concurrence (apply*; e.g., “Because I have a mental illness I am to blame for my problems”), and *self-esteem decrement (harm*; e.g., “I currently respect myself less because I am to blame for my problems”). These 20 items are measured on a Likert-Type scale from one to seven (1 = strongly disagree, 7 = strongly agree, 8 = N/A). In previous analyses, Corrigan et al. (2012) tested the SSMI-SF with three populations. While overall reliability reached acceptable range, the third subscale (apply) had low reliability ( $\alpha = .22$ ). The third subscale had low, but acceptable, reliability in the current analysis ( $\alpha = .63$ ). The three other subscales utilized (aware, agree, and harm) had sufficient reliability ( $\alpha = .91, .72$ , and  $.80$ , respectively).

## **Procedure**

Participants were gathered through craigslist posts, social media posts, and the Depression and Bipolar Support Alliance (2016). Individuals were eligible to participate if: they were diagnosed with bipolar disorder I/II (with comorbidity allowed), were diagnosed by a mental health professional, and had at least one romantic relationship for three months or longer.

Participants were directed to follow the link taking them to the online survey on Qualtrics.com. They were then prompted with a consent form before proceeding. After providing

informed consent, participants answered the online survey questions, which took approximately 11 minutes. The survey included demographic information, relational information, open-ended questions about hurtful messages, and the three scales assessing perceived hurtfulness, attributions, and self-stigma mentioned above (see Appendix A). Upon completing the survey, participants were thanked for their time and prompted to exit the web page.

## **Analysis**

The online survey data was exported from Qualtrics for analysis. First, the data was cleaned. Responses were removed if: the survey was incomplete, the participant had not received a hurtful message from their partner, or the participant was self-diagnosed with Bipolar Disorder I/II (rather than by a mental health practitioner). Next, the researcher gathered and analyzed frequencies and descriptive results for demographic information, relational information, and perceived hurtfulness of the message. Next, the short answer qualitative data (the hurtful messages) were coded using Vangelisti's (1994) pre-established hurtful messages typology. The researcher and the researcher's advisor served as primary and secondary coders, and examined the data using the pre-established coding scheme, the unit of analysis being the first message reported (including rare cases in which more than one message was stated). The coders discussed the categories and refined the coding criteria to establish coding rules. The two coders engaged separately in one round of tentatively coding the data set to familiarize themselves with the codes and to identify the need to extend or change the coding scheme. Due to the small number of responses nearly the entire data set was used for this process. Subsequent to the first round of coding the two coders engaged in a general discussion of the areas of difficulty in applying the codes, and further refined the coding scheme and rules. The coders engaged in a second round of coding, this time comparing their codes on each case after coding was completed to calculate

simple inter-coder reliability (73%). After this refinement of the codes and the calculation of inter-coder reliability, the primary coder completed all codes for the hurtful messages. Next, the researcher calculated reliability scores for the perceived hurtfulness of the message, context-specific attributions, and SSMIS-SF measures. Finally, the researcher ran a one-way ANOVA to test the associations of H<sub>1</sub>, and correlation analyses were used to test the associations hypothesized in H<sub>2</sub> and H<sub>3</sub>.

## Results

### Types of Hurtful Messages (RQ<sub>1</sub>)

As noted previously, types of hurtful messages were coded using Vangelisti's (1994) pre-established hurtful message typology. Due to a small sample size and the desire for more power among results, these ten themes were further collapsed into four larger themes: *assessment* (accusation/evaluation), *admonition* (directive/advise), *rejection* (express desire/inform), *minimization* (question/joke), and *miscellaneous* (lie/threat/uncategorizable). These supra themes were established by considering similar qualities among messages coded within subthemes. For instance, assessments (accusation/evaluation) often included judgements about the person's mental state, worth, or quality; admonition (directive/advise) encompassed messages that used the terms "would" or "should;" rejection (express desire/inform) included messages often stating that the participant desired relationship termination, or stated that they were ending the relationship; and minimization (question/joke) represented qualities of messages that either joked about the partner's diagnosis, questioned the partner's credibility, or insulted the partner in some other way. Finally, miscellaneous was comprised of lies and threats, which did not occur significantly in the data, as well as any messages that lacked qualities allowing for any available category (e.g., messages communicating nonverbal behavior or vague descriptions of

interactions). All in all, the data collected about hurtful messages comprised complex qualities that could be categorized more appropriately in larger groups. The results were 38 (38.4%) assessment, 13 (13.1%) admonition, 30 (30.3%) rejection, 13 (13.1%) minimization, and 5 (5.1%) miscellaneous. See Table 1 for complete representation of themes, definitions, and examples.

Further exploration of various message types revealed characteristics unique to the mental health context. For instance, assessments often included the word “crazy” or other forms of (de)valuation of the diagnosed individual’s quality or character. A majority of the hurtful messages also illustrated partners scapegoating; participants explained that their partners often invalidated their emotions and reactions because they have a mental health diagnosis. This invalidation may occur due to the characteristics of a bipolar diagnosis (e.g., inconsistent moods), which may result in unwarranted discredit of the diagnosed partner. A portion of participants within the assessment theme conveyed similar experiences, noting that the messages they received from their partners evaluated their credibility and soundness of mind. Specifically, 34.2% of messages categorized as assessment included the terms “crazy,” “delusional,” “psycho,” and “nut job.”

### **Hurtful Message Severity (H<sub>1</sub>)**

Hypothesis 1 predicted variance among types of hurtful messages and message severity. Overall, message hurtfulness ratings ranged from two to seven ( $M = 6.08$ ,  $SD = 1.09$ ). To test hypothesis 1, I conducted a one-way ANOVA between hurtful message types and perceived hurtfulness of the message (see Table 2 and Table 3). There was no significant relationship between hurtful messages and hurtful message severity. There was not a significant effect of hurtful message types on message hurtfulness [ $F(4, 94) = 1.33$ ,  $p = .265$ ]. H<sub>1</sub> was not supported;

however, messages did vary somewhat in mean severity (assessment  $M = 6.21$ , rejection  $M = 6.17$ , minimization  $M = 5.77$ , admonition  $M = 5.62$ , and miscellaneous  $M = 6.60$ ).

### **Self-stigma and Attribution (H<sub>2</sub>)**

Hypothesis 2 predicted that self-stigma scores would be negatively related to responsibility/blame attributions of hurtful messages from romantic partners. To test this hypothesis, I ran a one-tailed bivariate correlation between each of the SSMIS-SF sub-scales and context-specific attributions. There was a positive insignificant correlation between awareness and context-specific attribution ( $r = .154, p > .05$ ), and a negative insignificant correlation between agreement and context-specific attribution ( $r = -.105, p > .05$ ) and application and context-specific attribution ( $r = -.146, p > .05$ ). However, there was a negative significant correlation between harm and context-specific attribution ( $r = -.263, p < .01$ ), indicating that as levels of self-stigmatization harm increased, levels of partner responsibility/blame decreased. Overall, H<sub>2</sub> received mixed support (see Table 4 for correlations).

### **Message Severity, Attribution, and Self-stigma (H<sub>3</sub>)**

Hypothesis 3 predicted that hurtful message severity will vary by the diagnosed partner's level of responsibility/blame attributions and self-stigma scores. First, to test message severity and responsibility/blame attributions, I ran a two-tailed bivariate correlation between levels of perceived hurtfulness of the message and context-specific attribution scores. The results showed a significant negative correlation between context-specific attribution and hurtful message severity ( $r = -.273, p < .01$ ). In other words, the more a partner was seen as blameworthy for sharing the message (i.e., unwarranted in doing so), the less hurtful the message was (see Table 5).

Next, to test the relationship between message severity and self-stigma levels, I ran a two-tailed bivariate correlation between levels of perceived hurtfulness of the message and SSMIS-SF scores. Results indicated no relationship between the four SSMIS-SF sub-scales and message hurtfulness. Thus, H<sub>3</sub> was partially supported.

## **Discussion**

This study informs the literature about attribution theory, showing that attributional behaviors relate to both self-stigma and hurtful message severity in several ways. This discussion first begins with a general exploration of findings relating to each variable under consideration, followed by a specific discussion surrounding attribution theory, and practical applicability of these discoveries.

### **Hurtful Messages**

The primary research question in this study investigated the types of hurtful messages individuals diagnosed with bipolar disorder have received from their romantic partner about their diagnosis. After working from Vangelisti's (1994) hurtful message typology, several findings resulted. First, hurtful messages in this population were better suited to a five-theme structure to explain the data (i.e., *assessment*, *admonition*, *rejection*, and *minimization* and *miscellaneous*). Notably, two hurtful message types, *threat* and *lie*, did not emerge in participants' reports of hurtful messages they received from their romantic partners. This five-factor typology, though not as varied as Vangelisti's (1994) hurtful message typology, highlights the specific types of messages participants received about their bipolar diagnosis that caused hurt.

The first hypothesis predicted that hurtful messages would vary in perceived severity. While this hypothesis was not significantly supported, the results of the ANOVA do offer vital insights. According to Vangelisti (1994), relational-type messages (e.g., about the relationship)

and informative messages are more hurtful than other types of messages. However, in this study, hurtful messages did not significantly differ in severity, as all types of messages about bipolar disorder from romantic partners were considered quite hurtful. This study therefore presents an interesting phenomenon insofar as messages surrounding an uncontrollable personal characteristic (e.g., bipolar disorder) were more than moderately hurtful (mean message severity ranged from 5.62 to 6.60 on a seven-point scale).

Although there were no significant differences in message type and all hurtful messages reported were rated as more than moderately hurtful, two message categories, assessment and rejection, did show a trend toward the highest severity rating ( $M = 6.21$  and  $M = 6.17$ , respectively), and were reported most frequently. These ratings imply that these two types of messages may carry unique qualities. First, rejections encompassed messages of information, which supports Vangelisti's (1994) assertion that informational messages are most hurtful because they state information that the receiver cannot change or prove differently. Next, as discussed above, assessment messages often judged the receiving participant as "crazy," unstable, or of low personal quality. Due to the message content, these messages unsurprisingly received the highest severity rating, while the frequency of these message types supports previous research showing these categories of messages occurring more often in other hurtful message contexts.

Additionally, while a small portion of messages were coded as "miscellaneous," this category had the highest mean severity ( $M = 6.60$ ). The fairly high miscellaneous category's severity rating can be explained through various potential reasons. First, this study specifically examined *verbal* hurtful messages; thus, messages sent nonverbally through actions (e.g., the partner leaving the diagnosed individual), were not placed into a verbal category. Second,



miscellaneous messages that communicated rejection through action may be especially severe because, from an attribution perspective, if an individual highly self-stigmatizes, a partner's rejection may be internally attributed to the receiver's diagnosis, despite lacking a verbal message specifically communicating intentions or reasoning. Finally, these miscellaneous messages containing vague information were possibly reported ambiguously because the interaction was too painful or severe to specifically recount.

Importantly, hurtful messages do traditionally vary in severity (Vangelisti, 1994). This study asserted that some types of messages would be more severe than others in the context of romantic partners in which the receiver has a bipolar disorder diagnosis. Contrary to this hypothesis, however, hurtful messages did not significantly vary in severity by type of message. This reveals that the topic surrounding the hurtful message (in this case, bipolar disorder) may be more significant to severity ratings than how the partner delivers the message (hurtful message type) in some contexts, especially when the hurtful message concerns a lifelong diagnosis. Similar to informative-type messages, which are more difficult to refute, hurtful messages about a quality an individual has and cannot change may be especially hurtful.

### **Self-stigma and Context-specific Attributions**

The results of this study also lend insights into the nature of self-stigma and context-specific attributions concerning a mental health diagnosis. The second hypothesis predicted that self-stigma scores would be negatively related to responsibility/blame attributions of hurtful messages from romantic partners. The only significant relationship found existed between harm and responsibility/blame on partner. More specifically, higher levels of self-stigma internalization (resulting in harm to self) relate to more exoneration of one's partner. This

finding means that the more an individual accepts the perceptions of stigma as valid, the more they may also think their partner is valid in saying something hurtful.

Notably, Corrigan et al. (2012) explained that the four subscales of the SSMI-SF operate through a progression, whereby an individual gradually internalizes to a higher degree as they move through awareness, agreement, application, and harm. Therefore, these results suggest that once an individual has reached the highest level of internalized stigma, they remove responsibility/blame from their romantic partner for uttering a hurtful message about their stigmatic trait.

Next, the third hypothesis predicted that hurtful message severity will vary by the diagnosed partner's level of responsibility/blame attributions and self-stigma scores. The significant findings of hypothesis three inform findings from hypothesis two by showing how external attributions are related to less hurtful message severity felt by the receiver. Specifically, there was a negative relationship between attribution and message severity, meaning that when partners were considered at fault for uttering the hurtful message (i.e., an external attribution), the message was considered less hurtful. The inverse of this finding also suggests that when the diagnosed individual considers their partner less blameworthy, hurtful messages were more severe. These correlations illustrate how responsibility/blame shifts in relation to the recipient's own level of self-stigma and thus alters perceived message hurtfulness.

### **Theoretical Implications**

The current research offers a few theoretical implications surrounding attribution literature, as well as its relation to stigma and mental health diagnoses. First, this study indicates that message severity correlates with attributions. A message is more hurtful when less blame is placed on the partner (thus exonerating the partner), and less hurtful when more blame is placed

on the partner. In attribution theory, individuals typically attribute positive behavior to themselves (internally), and negative behavior to others (externally; Kelley & Michela, 1980). In this case, if the receiver of a hurtful message cannot attribute the cause of the message externally (e.g., place blame on the partner), then the message severity increases. The stigma of an unchangeable characteristic about the self, then, is connected to less self-serving attribution behaviors than would be expected based on studies of schematic attribution patterns (Kelley & Michela, 1980). In this context, a paradox potentially emerges, wherein individuals may be motivated to protect themselves by blaming a partner, but increased self-stigma about an internal, unchangeable characteristic relates to lowered ability to engage in self-protecting attributional biases, resulting in endorsement of their partner's warrant to make hurtful statements to them. Thus, the current findings highlight how attributions function in situations in which negative behavior is not externally attributed.

Second, the present study extends attribution theory and the implementation of context-specific attribution measures. While previous research has explored general attributions of hurtful messages, to date, no known research utilizes Backer-Fulghum et al.'s (2016) context-specific attribution measure. Importantly, this approach enhances the validity and reliability of the authors' measure. Additionally, this study re-affirms Backer-Fulghum et al.'s (2016) case that context-specific attributions offer situational insights into how individuals form attributions, rather than simply considering more general attributional decision-making.

Context-specific attributions also prove particularly useful when examining bipolar disorder. Defining characteristics of bipolar disorder include variable moods, and cycling between manic/hypomanic and depressive states. Attributions traditionally measure behavior based on global, stable, and controllable levels. Bipolar disorder (as well as other mood

disorders) presents with mood instability and less controllable cycling. As such, the nature of bipolar disorder as a diagnosis encompassing inconsistent mood and behavior can be most appropriately measured at context-specific levels.

### **Practical Implications**

Practically, this study presents implications concerning interventions for couples in which at least one partner has a mental health diagnosis. Applying general attributional tendencies to hurtful messages diagnosed individuals receive from a romantic partner runs the risk of viewing a single interaction too broadly. By utilizing the context-specific attribution approach, this study focused on a particular event that participants identified as personally hurtful, and then made meaning of the degree of responsibility/blame receivers felt their partner deserved. Through this approach, the study also provides specific instances of verbal transgressions an individual with a mental health diagnosis has experienced with their partner. Further, the data illustrates a clear typology of frequent types of hurtful messages that are received about bipolar disorder, and explains some of the nuances about severity and attributions of those messages.

Additionally, the results of this study indicate that lower levels of internalized stigma (e.g., lack of progression to the final level of self-stigma, *harm*) correlate with more responsibility/blame placed on partner, and thus the possibility that the diagnosed individual may hold their partner accountable for their hurtful message. In a therapeutic setting, these findings can help practitioners build interventions wherein clients may explore situational transgressions with their romantic partners and provide them with the tools to respond to hurtful messages (rather than working from more general attributional tendencies). Indeed, Backer-Fulghum et al. (2016) specifically noted that attribution assessments at the schematic and contextual level for developing and tracking therapeutic interventions. Schematically, partners may make general

attributions about their relationship, but attributions do not necessarily remain consistent along a variety of transgressions. One potential individual-level intervention could be noting a patient's level of self-stigma and their tendency to exonerate their partner for hurtful events, thus providing the patient with tools to speak up and hold their partner accountable for hurtful messages when necessary. Providers may also note a client's level of self-stigma when they feel hurt after receiving feedback from a partner that may be valid, or not intentionally relating to their partner's bipolar disorder. A second, couple-level intervention, considering that all types of hurtful messages about a partner's bipolar disorder are more than moderately hurtful, might involve teaching couples to anticipate occasionally having to engage in difficult conversations, and providing them with skills to navigate such conversations productively. These interventions may be broadly applicable for individuals or couples who live with other stigmatic characteristics, as they help to realize the role of someone's personal self-perceptions in relation to how they attribute feedback from others.

This study also hints at some indirect implications for further consideration. According to Hinshaw (2005) mental health diagnoses, traditionally considered stigmatic traits, are often considered onset-controllable and stable. When someone does something that is considered under their control, they receive less open, voluntary support (Thoits, 2011). Practically, this implies that while this study specifically examined the diagnosed individual's level of internalized stigma, their partner may hold those stigmatic views, which could influence the content of their hurtful messages. In other words, when a partner says something hurtful (especially calling them "crazy" or insisting they act differently) regarding a mental health diagnosis, their partner may be assuming that their behavior is under their control, which perpetuates stigma. These results tentatively imply that hurtful message reception in relation to

internalized stigma is not the only factor for examination; conversely, stigmatic views held by outsiders likely influence the delivery of the message. Although this data cannot directly support this speculation, past research confirms such notions (e.g., Weiner et al., 1988).

Additionally, based on some particularly hurtful terms present in the provided data, message content merits attention. According to Hinshaw (2005) stigmatized traits do not affect individuals in a vacuum, and sometimes people closely related to stigmatized individuals tend to feel such effects. Thus, the content of the messages may reveal goals of romantic partners in creating distance from their diagnosed partner—potentially in an attempt to “other” them, emphasizing that they are different from their diagnosed partner. Taken together, this study emphasizes the (potentially problematic) complexity of how stigmatized traits are conceptualized and treated by society, as well as how partners send and receive messages of hurt that may produce distancing effects.

### **Limitations and Future Research**

This study could be improved in a few ways. First, due to the selective inclusion/exclusion criteria for a sensitive population, the number of participants in this study was fairly small, thus failing to show even distribution between groups in the hurtful message types. Future research should aim for larger sample populations to better run powerful analyses. This sample population also comprised of an uneven gender representation (73.7% female), which is unrepresentative of bipolar diagnoses in the general population, with equal male and female diagnoses (NAMI, 2017). However, symptoms of bipolar disorder present differently in men and women, particularly in cycling patterns and considerations for course of treatment (Arnold, 2003). For instance, women tend to experience rapid cycling more often than men, and are more likely to experience misdiagnosis, resulting in delayed proper treatment (Arnold, 2003).

Since many hurtful messages included variations of the term “crazy,” future research should explore the intersections of stigma surrounding mental health diagnoses, gender, and communicating about emotion.

Second, a key factor in both hurtful messages and attributions is perceived intentionality. Feeney (2004) and Vangelisti (1994) explained that messages are more hurtful if they are considered intentional. Asking participants about perceived intentionality would provide a larger picture of the reception and attribution of hurtful messages. Second, past research explained that emotional closeness between partners affects attributions, such that partners who were close attributed negative experiences with their partners as unstable, external, and less global. Future research should consider the emotional closeness between partners and attributions for hurtful messages.

Next, although this study offers beginning insights into the reception of hurtful messages concerning a mental health diagnosis, it explores only one relational context: romantic relationships. Future research should examine hurtful messages about bipolar disorder received in other types of relationships, such as interactions among family members, friends, or others. Additionally, because this research uncovers nuances in the exchange of hurtful messages in various settings, further illustrating how these messages function contextually. Finally, because attribution theory not only helps individuals make sense of past experiences, but also helps in generating future expectations (Heider, 1958; Manusov & Spitzberg, 2008), future research should explore how hurtful messages about a person’s mental health diagnosis elicits responses and affects future behavior within the dyad.

### **Conclusion**

Hurtful messages occur in various relationships, but messages received from a romantic

partner are particularly hurtful. This study asserts that hurtful messages individuals diagnosed with bipolar disorder receive from a romantic partner represent a unique context, where they may be affected by the type of message, the receiver's degree of internalized stigma, and the resulting attributions the receiver makes. While participants received a variety of types of hurtful messages, each of the message types were rated as more than moderately hurtful. Message hurtfulness was additionally related to context-specific attributions about the message, and these attributions related to levels of self-stigma harm. The results of this study advance research surrounding mental health diagnoses, self-stigma, and context-specific attributions.



## References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.
- Arnold, L. M. (2003). Gender differences in bipolar disorder. *Psychiatric Clinics of North America*, 26, 595-620. doi:10.1016/S0193-953X(03)00036-4
- Backer-Fulghum, L., Anders, C., & Sanford, K. (2016). Assessing context-specific attributions during couples conflict interactions. *Assessment*, 1-12. doi:10.1177/1073191116662909
- Bauerle, S. Amirkhan, J., & Hupka, R. (2002). An attribution theory analysis of romantic jealousy. *Motivation and Emotion*, 26, 297-319. doi:10.1023/A:1022871104307
- Bradbury, T. N., & Fincham, F. D. (1990). Attributions in marriage: Review and critique. *Psychological Bulletin*, 107, 3–33. doi:10.1037//0033-2909.107.1.3
- Corrigan, P. W., Michaels, P. J., Vega, E., Gause, M., Watson, A. C., & Rüsçh, N. (2012). Self-stigma of mental illness scale—short form: Reliability and validity. *Psychiatry Research*, 199, 65–69. doi:10.1016/j.psychres.2012.04.009
- Corrigan, P. W., & Watson, A. C. (2002). The paradox of self-stigma and mental illness. *Clinical Psychology: Science and Practice*, 9, 35-53. doi:10.1093/clipsy.9.1.35
- Crowe, A., & Lyness, K. (2014). Family functioning, coping, and distress in families with serious mental illness. *The Family Journal: Counseling and Therapy for Couples and Families*, 22, 186-197. doi:10.1177/1066480713513552
- Depression and Bipolar Support Alliance. (2016). Bipolar disorder statistics. Retrieved from [http://www.dbsalliance.org/site/PageServer?pagename=education\\_statistics\\_bipolar\\_disorder](http://www.dbsalliance.org/site/PageServer?pagename=education_statistics_bipolar_disorder)

- Drapalski, A. L., Lucksted, A., Perrin, P. B., Aakre, J. M., Brown, C. H., DeForge, B. R., & Boyd, J. E. (2013). A model of internalized stigma and its effects on people with mental illness. *Psychiatric Services, 64*, 264-269. doi:10.1176/appi.ps.001322012
- Feeney, J. A. (2004). Hurt feelings in couple relationships: Towards integrative models of the negative effects of hurtful events. *Journal of Social and Personal Relationships, 21*, 487–506. doi:10.1177/0265407504044844
- Fincham, F. D., & Bradbury, T. N. (1992). Assessing attributions in marriage: The relationship attribution measure. *Journal of Personality and Social Psychology, 62*, 457-468.
- Hahlweg, K. (2005). The shaping of individuals' mental structures and dispositions by others: Findings from research on expressed emotion. *Interaction Studies, 6*, 131-144. doi:10.1075/is.6.1.10hah
- Harvey, P., & Martinko, M. J. (2010). Attribution theory and motivation. In N. Borkowski (Ed.), *Organizational behavior in health care, 2nd edition* (pp. 147-164). Boston: Jones and Bartlett.
- Heider, F. (1958). *The psychology of interpersonal relations*. New York, NY: Wiley.
- Hinshaw, S. P. (2005). The stigmatization of mental illness in children and parents: Developmental issues, family concerns, and research needs. *Journal of Child Psychology and Psychiatry, 46*, 714-734. doi:10.1111/j.1469-7610.2005.01456.x
- Hlastala, S. A., & Frank, E. (2006). Adapting interpersonal and social rhythm therapy to the developmental needs of adolescents with bipolar disorder. *Development and Psychopathology, 18*, 1267-1288. doi:10.1017/S0954579406060615

- Kelley, H. H., & Michela, J. L. (1980). Attribution theory and research. In M. R. Rosenzweig & L. W. Porter (Eds.), *Annual review of psychology* (Vol. 31, pp. 457-501). Palo Alto, CA: Annual Reviews.
- Kilk, K. (2015). *Risk and protective factors of internalized mental illness stigma* (Unpublished doctoral dissertation). East Tennessee State University, Johnson City, Tennessee.
- Mak, W. W. S., & Wu, C. F. M. (2006). Cognitive insight and causal attribution in the development of self-stigma among individuals with schizophrenia. *Psychiatric Services, 57*, 1800-1802.
- Manusov, V., & Spitzberg, B. H. (2008). Attributes of attribution theory: Finding good cause in the search for theory. In D. O. Braithwaite & L. A. Baxter (Eds.), *Engaging theories in interpersonal communication* (pp. 37-49). Thousand Oaks, CA: Sage Publications.
- National Alliance on Mental Illness. (2017). Bipolar disorder. Retrieved from <https://www.nami.org/Learn-More/Mental-Health-Conditions/Bipolar-Disorder>
- National Institute of Mental Health. (2017). Bipolar disorder. Retrieved from <https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml>
- Rittenour, C. E., & Koenig Kellas, J. (2015). Making sense of hurtful mother-in-law messages: Applying attribution theory to the in-law triad. *Communication Quarterly, 63*, 62-80. doi: 10.1080/01463373.2014.965837
- Thoits, P. A. (2011). Mechanisms linking social ties and support to physical and mental health. *Journal of Health and Social Behavior, 52*, 145-161. doi: 10.1177/0022146510395592
- Vangelisti, A. L. (1994). Messages that hurt. In W. R. Cupach & B. H. Spitzberg (Eds.), *The dark side of interpersonal communication* (pp. 53-82). Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.

Weiner, B. (1985). An attributional theory of achievement motivation and emotion.

*Psychological Review*, 92, 548-573. doi:10.1037/0033-295X.92.4.548

Weiner, B., Perry, R., Magnusson, J., & Reis, H. T. (1988). An Attributional Analysis of

Reactions to Stigmas. *Journal of Personality and Social Psychology*, 55, 738-748.

Young, S. L. (2004). Factors that influence recipients' appraisals of hurtful communication.

*Journal of Social and Personal Relationships*, 21, 291-303.

doi:10.1177/0265407504042833

## Tables

Table 1  
*Hurtful Message Themes*

Themes	Frequencies	Definitions	Examples
Assessment (Accusation/Evaluation)	38(38.4%)	A charge of fault or offense/  A description of value, worth, or quality	“I was told that I'm defective.”  “One time we were fighting and my partner bought up my condition and said it wasn't even real and I am just crazy on my own.”
Rejection (Express Desire/Inform)	30 (30.3%)	A statement of preference/  A disclosure of information	“She returned to home and started to talk about divorce as it is waste to lead rest of the life with me.”  “Said he didn't like being limited by what I could and couldn't do according to my mental illness.”  “My most recent partner discussed with me about how since I was bipolar, she was having trouble believing me because I ‘acted normal.’”
Admonition (Directive/Advise)	13 (13.1%)	An order, set of directions, or a command/  A suggestion for a course of action	“He said that I needed more help because he thought I was beyond crazy.”  “He said I need to keep calm and not let things upset me.”  “That I shouldn't be upset when he's lazy because there are days when I can't get out of bed to get anything accomplished.”

Minimization (Question/Joke)	13 (13.1%)	An inquiry or interrogation/  A witticism or prank	“She had asked me once why I couldn't just be normal like everyone else.”  “When I am having a crisis and am upset, he uses a mocking tone to mimic what I say.”
Miscellaneous (Including Threat/Lie)	5 (5.1%)	Unclassifiable	

*Note.* The subthemes, *Threat* and *Lie*, from Vangelisti (1994) were removed because no responses were coded as such

Table 2  
*Hurtful Message Types and Corresponding Severity*

Hurtful message	<i>N</i>	Mean	<i>SD</i>
Evaluation	38	6.21	.96
Rejection	30	6.17	1.18
Admonition	13	5.62	1.26
Minimization	13	5.77	1.17
Miscellaneous	5	6.60	.55
Total	99	6.08	1.09

Table 3  
*Hurtful Message Type and Severity ANOVA*

	Sum of squares	<i>df</i>	Mean square	<i>F</i>	Sig.
Between Groups	6.286	4	1.572	1.330	.265
Within Groups	111.067	94	1.182		
Total	117.354	98			

Table 4  
*Relationship Between SSMIS-SF and Responsibility-blame Attributions*

		Responsibility/blame attribution
Aware	Pearson Correlation Sig. (1-tailed) <i>N</i>	.154 .064 99
Agree	Pearson Correlation Sig. (1-tailed) <i>N</i>	-.105 .150 99
Apply	Pearson Correlation Sig. (1-tailed) <i>N</i>	-.146 .075 99
Harm	Pearson Correlation Sig. (1-tailed) <i>N</i>	-.263** .004 99

\*\*Correlation is significant at the .01 level (1-tailed).



Table 5

*Relationship Between Hurtful Message Severity, Responsibility-blame Attributions, and SSMIS-SF*

		Hurtful message severity
Aware	Pearson Correlation Sig. (2-tailed) N	-.055 .589 99
Agree	Pearson Correlation Sig. (2-tailed) N	-.081 .426 99
Apply	Pearson Correlation Sig. (2-tailed) N	.012 .905 99
Harm	Pearson Correlation Sig. (2-tailed) N	-.035 .733 98
Responsibility-blame attribution	Pearson Correlation Sig. (2-tailed) N	-.273** .006 99

\*\*Correlation is significant at the 0.01 level (2-tailed).

## Appendix A

### Questionnaire

#### Demographic Questions

*Please indicate how you would describe yourself in the following areas:*

1. How old are you? \_\_\_\_\_
2. What is your gender? \_\_\_\_\_
3. What is your race/ethnicity? \_\_\_\_\_
4. What is your highest level of education? \_\_\_\_\_
5. What is your sexual orientation? \_\_\_\_\_
6. What is your average yearly income? \_\_\_\_\_
7. What mental health diagnosis (diagnoses) have you received? \_\_\_\_\_
8. How were you diagnosed? \_\_\_\_\_

#### Relational Questions

*Next, please answer the following questions about your current relationship. If you are not currently in a relationship please answer these question about your most recent relationship.*

1. What is your current relationship status? \_\_\_\_\_
2. What is the length of your current or most recent relationship? \_\_\_\_\_
3. Were you diagnosed with Bipolar Disorder before your current/most recent relationship began? \_\_\_\_\_
4. If you were diagnosed with Bipolar disorder during your current/most recent relationship, approximately how long had you been in this relationship before your diagnosis?  
\_\_\_\_\_

5. Is/was your partner aware of your bipolar diagnosis? \_\_\_\_\_

### **Hurtful Messages**

6. Think of a time when your current/most recent partner said something that hurt your feelings. In as much detail as possible, please describe your partner's hurtful message in the space below.

\_\_\_\_\_

7. On a scale of 1-7, how hurtful was the message you received from your partner (1 = not at all hurtful, 7 = extremely hurtful)?

8. On a scale of 1-7, how much emotional pain was caused by the message (1 = did not cause emotional pain, 7 = caused a great deal of emotional pain)?

### **Context-Specific Attribution**

*Next, please answer the following questions indicating your level of agreement or disagreement with the following statements considering your partner's hurtful message (1 = strongly disagree, 6 = strongly agree):*

1. My partner purposefully shared a message that caused me to feel hurt. (R)

2. My partner is at fault for sharing this hurtful message. (R)

3. My partner's feelings are understandable.

4. My partner could have prevented my feelings of hurt. (R)

5. My partner is being reasonable.

6. My partner's viewpoint is valid.

## **Self-Stigma of Mental Illness**

*There are many attitudes about mental illness. We would like to know what you think most of the public as a whole (or most people) believe about these attitudes. Please answer the following items using the 9-point scale below (1 = strongly disagree, 9 = strongly agree, N/A = not applicable).*

### *Section 1: I think the public believes...*

1. Most persons with mental illness are to blame for their problems.
2. Most persons with mental illness are unpredictable.
3. Most persons with mental illness will not recover or get better.
4. Most persons with mental illness are dangerous.
5. Most persons with mental illness are unable to take care of themselves.

### *Section 2: I think...*

1. Most persons with mental illness are to blame for their problems.
2. Most persons with mental illness are unpredictable.
3. Most persons with mental illness will not recover or get better.
4. Most persons with mental illness are dangerous.
5. Most persons with mental illness are unable to take care of themselves.

### *Section 3: Because I have a mental illness...*

1. I am unable to take care of myself.
2. I will not recover or get better.
3. I am to blame for my problems.
4. I am unpredictable.

5. I am dangerous.

Section 4: *I currently respect myself less...*

1. Because I am unable to take care of myself.

2. Because I am dangerous.

3. Because I am to blame for my problems.

4. Because I will not recover or get better.

5. Because I am unpredictable.