

I'm Ok, You're Not: Assessing Variable Influence on Perceptions  
of the Mentally Ill Among College Students

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This project is dedicated to:

My wife—Jennifer Wagner

Without your unending support, I could not have made it this far.

I love you and normally I would follow that sentiment with a “☺,” but I’m not entirely sure that would be appropriate for a thesis project.

## Acknowledgments

My journey into academia has been...interesting. I entered college expecting to emerge as a rock star (no joke), making money by playing keys in some trendy, hipster band while traveling across the United States. 90 wasted credits hours in the music department later, reality set in and I decided that perhaps I should consider some new avenue. I toyed with the idea of communication studies, but quite honestly I was shy so I couldn't grasp the idea of a real career in such a field. I registered for journalism classes as electives and enjoyed them, but something did not quite click. I continued taking other communication courses and ultimately decided to go out on a limb and declare a new major. I walked into my advisor's office and when asked what my new field of choice was, I randomly blurted out that I wanted to study speech. The words didn't feel right coming out of my mouth. It was as if they were vomit that I didn't want to let out of my mouth, but, like it or not, they came. I walked out, and, after some *real* vomit from the reality of the huge decision that I had just made, I decided to test my fate.

Three years after that random advising meeting, I look back and laugh. I believe in God, and I think that this was His way of looking out for me. It took me just a few weeks to realize that I had finally found my field. I began to eat, live and breathe communication studies. I found a love for knowledge that I had never known before. I knew that I was where I was supposed to be. Along my journey, I have met people that have become like another family to me. Dr. William and Dr. Faith Mullen have had so much influence in not only my academic walk, but also in my personal life. Dr. Lynnda Beavers' office door has been routinely graced with my presence, and I very much appreciate the meaningful conversations that we've had over the years. Dr. Michael Graves has always graciously humored my ridiculous attempts at rhetorical criticism while Dr. Darlene Graves has always warmed me with her presence and asked about

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## Abstract

Due to the alarming level of stigma associated with individuals with a mental illness, this present study seeks to better understand the variables that influence perceptions of the mentally ill. The research questions for this study are as follows: RQ1: What are the latitudes of acceptance, rejection and non-commitment that college students identify in their perceptions of the mental health community?, RQ2: Does gender influence college student perceptions of the mentally ill?, and RQ3: Does the level of religious involvement that college students identify correlate to their perceptions of the mentally ill? The 257 participants completed an online survey that assessed their perceptions through demographic history, a Bogardus social distance scale and the Community Attitudes Toward the Mentally Ill (CAMI) assessment. The results indicated that participants held a largely positive and non-stigmatizing view of the mentally ill and that gender and religious involvement were not significant influents on perceptions of the mentally ill.

Key Words: Mental Illness, Stigma, Perceptions, Attitude Formation, Social Judgment Theory, Gender, Religious Involvement

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## Chapter 1—Introduction

Modern cinema has brought a great number of thrills into the living rooms of families across the globe. As time progresses, media has developed along with it. Sexualized themes grew throughout the 1960s as much in media as they did in the real world. Violence grew outside of the house, but television compensated by broadcasting violent themes to families in the comfort of their own homes. Media has been a great friend to many but has also had a detrimental influence on many social groups, including the mentally ill. Such media portraits carry weight and have the potential to alter the perceptions of those that view them. For the mentally ill, these mediated accounts can be partially accredited with the stigma that is associated to mental illness.

A current portrait of media shows that it is not interested in always providing “real” accounts of the current state of the world. From rich, glamorous “housewives” to crime dramas that break the laws of science and pathology, it should come as no surprise that media has painted a grossly inaccurate picture of many people groups. The mentally ill, in particular, have become the target of many inaccurate and far-fetched story lines, most of which paint them as dangerous or unfit to operate in the social realm (Wilson et al. 442). This media portrayal is not the focus of this research study. It does, however, warrant the attention of scholars and researchers to analyze further what shapes, guides and influences public perceptions of those with a mental illness, disease or defect (Hyler et al.).

While much research has focused on the mental health community previously, the mentally ill are still a highly stigmatized social group (Berzins et al.; Kelly and McKenna). Scholars have yet to determine the true source of stigma, but whether through mediated portrayals or other social means, most agree that the mentally ill are endowed with a negative social label (Berzins et al.). Because this stigma still thrives, it is of the utmost importance that

professionals from all disciplines make an attempt to understand better the roots of this stigma, the implications it has on social relationships and ultimately its effect on society as a whole.

In response to this problem, many scholars have focused their studies on public perceptions of the mental health community. Studies of this sort vary in focus, ranging from the stigmatization of the mentally ill in popular television (Beveridge; Pirkis et al.; Signorielli; Wilson et al.), mainstream news media (Slopen et al.; Tankard and Adelson; Thornton and Bev Wahl), and even in the general population itself (Cohen; Grierson and Scott; Taylor and Dear). While research on this subject abounds, most published studies fail to focus on specific variables, choosing instead to take a generalist approach. These previously published reports have illuminated relevant data, but, as mentioned, have done little to reduce the stigma associated with the mentally ill.

If social stigmatization of the mentally ill is to be fully understood, researchers must examine possible variables that lead to negative perceptions of the mentally ill. As mentioned, while many established studies exist on this matter, most fail to address the specificities that surround public opinion and perceptions of the mental health community. Additionally, many established studies fail to interpret their research under a guiding theoretical framework. These two qualifications set this research study apart. It seeks to look at specific variables for statistical significance and interpret those results under the guiding latitudes of acceptance, rejection and non-commitment of Sherif's Social Judgment Theory.

By using established research tools to quantifiably measure individual's perceptions of the mentally ill, this study will be of use to researchers from a variety of fields, simply because of their "long experience and familiarity with quantitative approaches" used in this field of study (Cheek et al. 147). These methods have been used previously and are a valuable asset to this

study because they effectively measure two important elements related to the study: social distance and perceptual frameworks. Researchers will benefit from that data collected because it provides a rich, quantitative examination into the perceptions of a student sample.

This study will rely on tried and true surveys to measure student perceptions. Through the use of the Community Attitudes of Mental Illness (CAMI) test and a Bogardus social distance scale, results will help researchers better understand the scope of desired contact that such a population has with the mentally ill. Each component will work with the other to provide the richest data possible in an effort to contribute focused research on this area of study. The purpose of this study is not only to add to the growing literature on public perceptions of the mentally ill, but also to understand how variables influence the overall perceptual worldview of individuals.

This study is of particular interest to a vast array of audiences, including those in the mental health community, health care, sociology, and communication-based fields. Specifically, the theoretical implications of this study and its examination of perceptions is of special value to the entire discipline of communication studies. Although few communication-based studies exist—with the exception of those related to health communication (Klin and Lemish; Pirkis et al.; Slopen et al.)—the topic of this study is related to the practice of communication itself, especially studies of persuasion and public relations. The component on perceptions is also of interest to communication scholars because of the influence that perceptual frameworks have on interpersonal and professional communication contexts. This relationship between perceptions and communication demands the attention of communication scholars because it helps to bring about greater understanding of the intrapersonal processes that influence communicative action and practice.

Throughout the following literature review, methodology and discussion of research results, themes related to perceptions and social distance will be examined. In an effort to understand better the intricacies surrounding perceptions of the mentally ill, this research study will focus on specific variables to test if they are a significant source for perceptual foundations. Specifically, it will examine the role of gender and religious involvement to see if they emerge as significant influents on perceptions of the mentally ill. Additionally, it will attempt to assess the latitudes of acceptance, rejection and noncommitment that individuals have when determining their perceptions of the mentally ill. The guiding research questions for this study are as follows:

**(RQ1)** What are the latitudes of acceptance, rejection and non-commitment that college students identify in their perceptions of the mental health community?

**(RQ2)** Does gender influence college student perceptions of the mentally ill?

**(RQ3)** Does the level of religious involvement that college students identify correlate to their perceptions of the mentally ill?

In order to fulfill this research goal, it is important to understand how perceptions of the mentally ill have been previously studied. As mentioned, many scholars have focused on the mental health community, but their scholarship has done little to reduce the existing stigma. The following review of literature will discuss significant studies that have focused on community and professional perceptions of the mentally ill, as well as the role that media plays in the social structuring of perceptions. Additionally, it will discuss the guiding theoretical framework under which the subsequent methodology has been structured.

## Chapter 2-Literature Review

Many research studies have attempted to assess and understand public perceptions of the mentally ill. For this study, it is important to understand the depth and the breadth that other studies have covered. Thus, this literature review will examine three distinct modes of research that apply to the overall methodology of this study.

First, an overview of mental illness and its impact will be discussed. Many studies have attempted to define, frame and test the true implications of mental disease and defect. These studies range in method, with scholars from quantitative, qualitative, mixed-methods and unconventional methodologies adding to the voluminous amount of research on the mentally ill. The first portion of literature will summarize some of these studies on the scope of mental illness.

Second, this literature review will examine media studies on the mentally ill. Historical backgrounds of such research serve as a gateway into the plethora of modern social science studies that assess the stigma associated with media representation of the mental health community. As will be discussed, media representations of the mentally ill have been shown to have significant influence on perceptions of the mentally ill. This section will focus on two specific arenas of media: journalistic and fictional, entertainment media.

Third, an overview of respected scales used to assess perceptions of mental illness will provide a scope for the broad range of categorizations that currently exist. A brief summary for three key perceptions scales will be given, along with the attributed studies associated with each scale's development. Implications and limitations of each scale will be discussed in an effort to determine the most accurate form of quantifying public perceptions.

Finally, this review will provide a detailed look at Muzafer Sherif's Social Judgment Theory and its implications for the study of public perceptions. Theory development, overview and implications will be discussed. Additional focus will be given to the studies of applicable value. Throughout the entire literature review, applications are made with the specific theoretical guidelines of Social Judgment Theory in mind. Additionally, all literature presentation has been organized in a way that reinforces the firm referent of the mental health community to which the methodology of this study is concerned.

### **Research on Mental Health Impact and Scope**

Mental health has been the specific focus of many studies that range in scope and thematic framework. It seems that no one is exempt from mental disease or defect and that it can strike any number of people that it wills. Mental illness in parents has proven to be a “well-established risk factor for psychological problems and mental disorders in the offspring: more than half of children will experience some psychological disorders in childhood or adolescence” (Siegenthaler, Munder and Egger 8). This association, as Siegenthaler and associates frame it, presents a sort of psychopathology, which combines genetic influences and factors along with environmental effects and parental symptoms. This psychopathology then plays a direct role in the genealogical roots of the family. This assertion is validated by other research reports (Reiss), including a longitudinal study conducted by Murray and associates, that showed a direct correlation between postnatal mother depression and adolescent depression later in life (Murray et al. 460-470).

A similar report by Westrupp and associates notes that psychiatric difficulties can occur as a result of a variety of different factors. In their assessment of children born preterm, with low birth weight or born at a small gestational age they find that regardless of low-to-moderate risk

(LTM), such a population with LTM perinatal risk were “at a small increased risk for emotional difficulties” (Westrupp et al. 313). Their results indicate that biological and socio-economic environments do play a significant role in the development of psychiatric problems in child more heavily than parenting styles, which is consistent with the findings of other studies (Murray et al.; Reiss; Siegenthaler et al. ).

These biological instances do play a significant role in the development of psychiatric problems for adolescents well into their teenage and adult years. Hayman notes that children with mentally ill parents are often placed into an odd role-reversal, forced to ensure the care of their parents or guardians. She notes that even when mentally ill parents seek support or help, that help is often directed on an individual, not on the familial level. Thus, children in households under the influence of a mentally ill parent are often up to 2.5 times more likely to suffer with difficulties in mental health (Hayman 268).

It is estimated that approximately 50-90% of people with chronic mental illness live with their relatives following psychiatric treatment of their condition (Lauber et al.). Thus, research findings show that caregivers (who often go untrained to deal with such mental disorders) are subject to higher levels of physical and mental health problems (Gallagher and Mechanic). A longitudinal study even revealed that over the course of a 15-year measurement, levels of distress for family caregivers of mentally ill persons were consistent and unwavering (Brown and Birtwhistle).

Essentially, mental illness is a brutal force. Not only does it significantly impact the social and mental capacities of those with a diagnosis, it also significantly impacts the lives of those who are forced to care for family members with such a disease. Mackay and Pakenham note that coping strategies to deal with the stresses related to mental illness come through a

variety of different channels and that no channels are necessarily more beneficial than the other. They assert that regardless of method, coping strategies are an effective way to make sense of mental illness and disease (Mackay and Pakenham 1064-1065).

Donohue-Smith conducted a study with a focus on sensemaking as it relates to mental illness. The study focused on the value of mental illness memoirs or autoethnographic portraits of mental disease. She asserts that the memoir “brings immediacy and ‘life’ to the constellation of symptoms commonly associated with established psychiatric diagnoses” (Donohue-Smith 138). This immediacy, she asserts, is an effective vehicle to educate future clinicians because it accommodates for the oft-forgotten “[narrative]...voice of the sufferer” and helps to deepen “understanding of both the nature of mental illness and of ‘what works’ to promote healing” (138).

This focus on sensemaking and meaning has also been the focus of many additional research studies. Flood and Farkas further discuss the importance of effective teaching in healthcare contexts by invoking an interdisciplinary perspective of teaching about the stigmatization of mental diseases. The authors of this research report document their experience as literary professors with interest in ethics and healthcare practices. The study birthed a course on the literary implications of mental disease and found that “the tools of literary theory and analysis are particularly useful for furthering the goals of understanding patients’ stories and thinking out of the silo” (133), with the figurative silo as the typical “monocultural approach that makes it difficult for students to see their own need for humanities studies” (129). Flood and Farkas conclude that examining mental illness from a multidisciplinary angle is valuable and is a beneficial supplement to the clinical education of practitioners (135).

Scholars have also found beneficial tools in the autobiographical accounts of mentally ill persons. A study by Woods explains that the contribution of first-person accounts of mental illness are a valuable source to clinicians because they go far beyond the standalone medical information. Woods examined two prominent autobiographies: Kurt Snyder's *Me, Myself and Them: A Firsthand Account of One Young Person's Experience with Schizophrenia* and Elyn Saks' *The Center Cannot Hold: My Journey Through Madness*. Woods' findings directly show that autobiographical accounts and memoirs are very effective in sensemaking and helping clinicians as well as mental patients understand their psychiatric diagnosis (105).

Taking one step further into the literary realm of mental illness, Roe and Garland propose that the use of poetry in psychotherapy is an effective method of framing behavioral construction. The authors propose that psychotherapy is a metaphorical journey taken by both the mentally ill and their clinical therapists; thus, the use of metaphor and literary theory are often an effective way of framing the healing experience. Like the previous studies above, they propose that there is no one effective way to make sense of a mentally diseased life, but propose that poetry, metaphor and other aspects of literary theory are helpful in the construction of meaning for the mentally ill, their clinical therapists and future healthcare professionals (Roe and Garland, 100).

Meaning is an essential component in studies on mental health. In defense of this research report, many scholars have proposed that mental illness is, in fact, worthy of scholarly study. In order to understand the many social, psychological, and health related themes associated with mental disease or defect, scholars from all disciplines have a call to further analyze such diseases. Many different units have been successful in measuring themes related to mental illness, and each varies in scope. As stated, the purpose of this research is to examine

variables related to perceptions of the mentally ill so that future health care providers can effectively reduce the stigma associated with such conditions. The above studies have noted the physical, psychological and theoretical nature of research on mental illness, yet it is also important to note how studies have focused on practical aspects related to mental illness. Such studies are summarized below.

### **Research on Mental Illness in the Media**

In order to quantify public perceptions of mental illnesses, considerations must first be given into the large pool of research that has been previously conducted with such a focus. The following portion of literature will present a vast array of research that has been conducted on the association between perception and stigma, beginning first with research that deals with media representation of mental illness and concluding with social scientific data on the effects of such stigma.

#### *Mental Illness Representations in the Non-Fiction Media*

Newspaper articles depicting the mentally ill have been repeatedly examined for their use of labeling in reference to the mental health community. Paterson notes that “embedded within the story or narrative of any newspaper story is [its] ‘frame’” (295). This frame is a guiding referent that shapes the entire narrative plot. It has the power to shape characters, events and timetables and serves as an anchor for readers (295-296). Framing is used to shape characters, including the mentally ill. Wahl notes that the negative framing of mental health individuals “perpetuates stigma and public fears of those with mental illnesses” and has an explicitly social result (1596).

Nairn, Coverdale and Coverdale assert that, overall, “mass media depictions of persons with mental illness are generally negative and stigmatizing” (202). This echoes the sentiment of

Gerbner states that the persistent framing of the mentally ill in a negative light reflect “deeply rooted and highly functional cultural mechanisms that maintain a social structure with all its inequities” (Gerbner 22). Thus, Nairn and associates establish four mechanisms that they assert define the mentally ill in media outlets.

First, they cite language and intertextuality as negative framing tools, pointing to the *New York Times* article on Andrea Yates, who drowned her five children in the bathtub of her house in the summer of 2001. They assert that the article’s focus on madness and homicide did much to “confirm the awesome power of madness, [and how] it can overthrow a mother’s love for her children, leading to actions that are both criminal and unthinkable” (Nairn, Coverdale and Coverdale 203). They discuss the intertextual implications that articles such as this have, specifically noting that “the phrase ‘maternal madness’ (which was a part of the article’s title) [can] be interpreted within a cultural history that includes ideas of (demonic) possession, Greek myths about the god-cursed mad, and crazed maenads who tore unbelievers apart, as well as the dangerousness of mad men and women” (203).

The second mechanism Nairn and associates note as a negative framing tool is culture. The researchers assert that American culture, in particular, is inundated since childhood with images of madness and self-destruction. They point to cartoons in which mad characters hit themselves or engage in other irrational behaviors. Although such behavior may be simplistic and juvenile, the authors assert that “these entertaining images are acculturating children into stigmatizing ‘adult’ conceptions of mental illness” and that it is “important to emphasize that the representation of characters who act in irrational, dangerous, and bizarre ways as mad is an identification that confirms cultural common sense about mental illnesses” (Nairn, Coverdale and Coverdale 203-204).

Social practices also play a significant framing role. Nairn et al. asserts that there is a “presumed inability of the mentally ill or ‘mad’ persons to control themselves,” and that this idea “intensely stigmatizing and providers further example...that people living with mental illnesses are often portrayed as violating relevant social practices” (204). The authors point to the *Richmond Times Dispatch* article after the 2007 Virginia Tech shootings with the headline “Mental Health Board Faulted in Cho’s Case,” and its allegations that improper mental health diagnostics had “failed the community” (205). Articles such as these, Nairn and associates claim, promote stigmatizing social practices against the mentally ill.

Finally, the authors assert that “organized care and support for people living with mental illness are currently the responsibility and *raison d’etre* of particular institutions known collectively as the mental health services” (Nairn, Coverdale and Coverdale 205). The authors note how mental illness is often framed as the ultimate asylum experience, complete with rejection and incarceration. They also assert that this portrayal typically carries an animalistic theme, complete with accounts of the mentally ill who are akin to “the Gadarene demoniac, who was too strong to be chained, constantly cried out...gashed himself [and was] feared by those living nearby” (205).

Nairn and associates build their case on the argument that “the media, like other groups, cannot be considered separate from these four cultural mechanisms when representing mental disorders or ‘madness’ or when ‘explaining’ unacceptable, deviant acts” (206). They propose three implications from their study. First, all of culture is immersed in certain connotative mechanisms and it is important to understand how those mechanisms are used to frame experiences. Second, literature about cultural mechanisms and mental illnesses ranges far beyond the implications measured in social scientific research on the stigmatization of the mentally ill.

Finally, they assert that even the use of mental-illness language (Andrea Yates, Looney Tunes, “Madman”) perpetuates stigma and the cultural construction of madness (Nairn, Coverdale and Coverdale 206).

Sloven and associates examined the coding of newspaper articles dealing with the mentally ill, examining a total of 1,252 articles documenting the dealings of such individuals and giving special attention to the age of the individual involved. Articles were coded for several elements, including type of article, type of mental disorder involved, themes of responsibility between mental illness and crime, and “elements of responsible journalism,” including the perspectives of professional mental health experts and physicians, providing of statistics and avoidance of slang or derogatory terminology (3,4).

Results show that articles are more likely to feature an adult mentally ill individual than a child, but stories about mentally ill children are likely to exceed the length (by at least one-hundred words) of similar articles with an adult subject (8-9). Aside from its specific purpose, Sloven’s article also provides a glimpse into the various negative stereotypes that are provided with newspaper representation of mental disease.

Thornton and Wahl assert that news sources are a major influent in the public attitudes toward mental illness. Through research, they posit that stories covering violent crimes committed by people with a documented mental health disorder are often characterized by “sensational headlines” and accentuate the “horrible nature” of such crimes, thus communicating a “connection between mental illness and violence,” and ultimately reinforcing public stigma and fear of individuals with mental health disorders (17-18).

In an effort to understand this phenomenon, a news story depicting a situation like those mentioned above was selected. The story documented a murder committed by a mentally ill perpetrator and gave specific attention to several key stigmatizing elements:

- (1) the tragic death of an innocent victim at the hands of a psychiatric patient;
- (2) a graphic description of the incident utilizing emotionally laden or attention-grabbing terminology; (3) an attention-grabbing headline with large letters and emotionally-charged words (“Girl, 9, stabbed to death at fair: Mental patient charged”); (4) a description of the mentally ill person who committed the act as different and without social identity; and (5) depiction of the mentally ill person as having some or all of the following qualities: unpredictable, dangerous, aggressive, strong, active, and irrational. (Thornton and Wahl 18)

Although there is much dialogue on the negative stereotypes of the mentally ill perpetuated by the journalistic media, little research exists that discusses this accusation from the point of view of the accused. One significant and related study has been found that deals with the comparison of perceptions of newspaper editors and the public toward mental illness. Grierson and Scott composed and distributed a survey assessing the perceptions of individuals with a mental health disorder to two specific demographics: the general public of the state of Alabama and newspaper editors from the same state. The results showed that editors have an overall more positive view of the mentally ill than the general public, considering them “less dangerous [and] unpredictable” (Grierson and Scott 99-101). Nevertheless, editors, according to this study, are still unlikely to hire a mentally diseased individual to work for their organization (95,100).

A plethora of research exists on the role of mental health representations in the journalistic circle. A study by Tankard and Adelson examined the newspaper advice columns of Ann Landers, Abigail Van Buren (“Dear Abby”), and Joyce Brothers for any themes related to mental illness and marriage. Each of these columns was searched for items dealing with mental health and marriage. Coders of the study compared items found in columns dealing with mental health against a list of 10 common misconceptions (compiled from a generic list of mental health statements from the public, experts and mass media). The 10 misconceptions, along with their explanations are as follows:

- (1) *Look and Act Different*. The mentally ill are recognizably different in manner and appearance from a normal person.
- (2) *Will Power*. Will power is the basis of personal adjustment.
- (3) *Sex Distinction*. Women are more prone to mental disorder than men.
- (4) *Avoidance of Morbid Thoughts*. Preoccupation with pleasant thoughts is the basis of mental health.
- (5) *Guidance and Support*. Mental health can be maintained by depending on strong persons in the environment.
- (6) *Hopelessness*. There is little that can be done to cure a mental disorder.
- (7) *Immediate External Environmental Versus Personality Dynamics*. The individual’s state of mental health is dependent on the pressures the immediate environment.
- (8) *Nonseriousness*. Emotional difficulties are relatively unimportant problems that cause little damage to the individual.
- (9) *Age Function*. Persons become more susceptible to emotional disorders as they grow older.
- (10) *Organic Causes*. Mental disorder is brought on by organic

factors like poor diet and diseases of the nervous system. (Tankard and Adelson 594).

These statements were then contrasted against a compiled list of seven major myths of marriage, which were compiled by Lederer and Jackson. Each item from this scale was coded in a way to determine its stance on marriage. Statements demonstrated positive, negative and irrelevant views in an effort to effectively compare the two myth scales. The seven misconceptions of marriage are as follows:

People marry because they love each other. Most married people love each other. Love is necessary for a satisfactory marriage. There are inherent behavioral and attitudinal differences between female and male, and these differences cause most marital troubles. The advent of children automatically improves a potentially difficult or unfulfilled marriage. Loneliness will be cured by marriage. If you tell your spouse to go to hell, you have a poor marriage (Tankard and Adelson 594).

The sample consisted of 83 “Dear Abby” columns, 95 Ann Landers and 69 Joyce Brothers columns, for a total of 247 columns. Of those, 179 columns contained items that dealt with mental health while 104 had items about marriage. The study found that Landers’ columns devoted 15.2% of their time to discussing mental health and Dear Abby’s devoting 6.4%. Brothers’ columns, since they specifically dealt with psychological issues, devoted almost 100% to topics of mental illness. When averaged together, the study found that 15.1% of the items about mental health supported one of the aforementioned myths of mental illness while 15.6% of the items refuted one of the myths. Still, 69.8% did nothing to support or refute a myth.

The authors conclude that the content analysis revealed an almost equal relationship between negative and positive casting of mental illness. Tankard and Adelson note that “the messages that received the greatest emphasis by the columnists were that mental health problems are serious, that they are not hopeless but are treatable, and that for many problems one should seek professional help” (Tankard and Adelson 597).

A study by Blood and Holland (2004) provides an in-depth discussion of news frames and their role in constructing risk knowledge for Australian newspaper readers. They argue the importance of risk information analysis, specifically because of the role that risk and crisis knowledge plays in contemporary public and political debate. To analyze this construction, they retrieved all news and features stories that had themes dealing with mental health, mental disease, mental patients and suicide from two major Australian newspapers published in December 2001 and January 2002. The authors found that because of recent events of the escape of psychiatric patient Mark Briscoe and an earlier escape by a patient named Claude John Gabriel, a news frame indicating a clear public crisis was evident. They are careful to note that these events possibly triggered the widespread interest in mental health that surrounds their study.

The study found that most news frames relating to the mentally ill had an enduring frame theme of violence. As they assert, the “alarmist, attention-grabbing information couple[d] with the perceived uncertainty” of the situations at hand continually framed the mentally ill as “paranoid,” “criminally-insane killer[s]” (Blood and Holland 328-329). This theme also merges into another frame: the community crisis. The authors note that “the agenda of the newspaper was clear: something must be done about the ‘crisis’ in the mental health system that had seen two mentally ill killers ‘walk free’” (330).

Two other frames contributed to this overall frenzy focused on the mentally ill. First, continued coverage led to “the news momentum” and “escalating community fear” (331). The authors note that the newspapers began to put hypothetical narratives in the eye gates of readers, using terms such as “danger patients” and “serious offenders,” to discuss mentally ill patients that had recently been released from the custody of the government (331-332). Thus, personalization of the risk was magnified in the final frame, which essentially “appealed to the principle that neighbors and employers should have the right to know the violent pasts of former mental patients when they are released into the community” (332). The study concludes with the assertion that frames selected for news stories about the mentally ill were seemingly selected because of their perceived newsworthiness, not because of their accuracy.

It is interesting to note that, specifically because of the research found in this 2004 article by Blood and Holland, complaints were lodged with the Australian Press Council by a variety of sources, including the Queensland Public Advocate, the Royal Australian and New Zealand College of Psychiatrists, the Association of Relatives and Friends of the Mentally Ill, the Schizophrenia Fellowship of South Queensland, Queensland Parents with a Disability, the Mental Health Association of Queensland and SANE Australia. As the authors note, “[f]raming choices always have consequences,” and in this case, action was taken to implement a required training session for employees of the Australian newspapers focused on sensitivity and appropriate framing techniques (Blood and Holland 339-340).

While a plethora of research exists on the role of mental health representations in the journalistic circle (Tankard and Adelson; Blood and Holland; Nairn and Coverdale), it is important to provide an overview of the representations of the mentally ill in all forms. As Signorielli asserts, “[t]elevision is our nation’s most common, constant, and vivid learning

environment” (325); thus, it is important to analyze how television and other forms of entertainment media provide representation of the mental health community.

### *Mental Illness Representations in Fictionalized Media*

Since society is categorized by transitions in leadership from generation to generation, it only seems appropriate to discuss the implications that media representation of mental illness has on children’s media. In a research overview by Wahl, he provides an analysis of mental illness occurrences in children’s film. Wahl asserts that psychiatric disorders that are evident in children’s media often “involve negative stereotypes similar to those in adult media” (254-255). Representations of such characters are often marked by violence, aggressions or fear (255). Additionally, Wahl provides evidence from children’s media that suggests the solution to the problem of mental illness is to isolate or confine such individuals, rather than exert empathy or suggest treatment (255).

In a study by Beveridge, the films of Walt Disney were analyzed for their depictions of mentally diseased or “mad” characters (618). The study asserts that the Walt Disney Company has repeatedly produced media that depicts mental disease throughout its existence as a media distributor (619). Beveridge points out that many of the main characters in the Disney films are often initially presented as “mad” but are ultimately declared sane through explanatory actions found in the narrative. Ultimately, the study concludes that madness is “generally presented as something to fear and something that needs to be shut away” (619-620).

One of the most in-depth studies concerning mental illness in children’s media, conducted by Wilson and associates, analyzed two New Zealand television channels over the course of an entire week. Two distinct time slots were analyzed, one in the early morning and one during the mid-afternoon. The study examined 128 episodes of children’s programming, 59

of which contained one or more references to mental illness. A total of 159 references were made in the programs, each in regard to various character actions (440-442). The study asserts that vocabulary concerning the mental health community in children's media is "predominantly negative with an implication of loss of control" (442).

In a study conducted by Minnebo and Van Acker, teenage television viewers from diverse educational backgrounds completed a self-report questionnaire, indicating their overall exposure to television programs and specific television content. Results showed that teenagers with a high exposure to crime-related and horror genre television shows were more likely to believe that the mentally ill are dangerous and violent (265). Additionally, the study asserts that "frequent viewers think less of the ability of people who have mental illness to lead a normal life and are more favorable about keeping them out of everyday life" (268).

Even through the transition to adulthood, depictions of mental illnesses are frequent in television programming. Fruth and Padderud explored representation of the mental health community on daytime television series in their 1985 study. Their findings show that 11.4% of daytime television series material is "devoted to discussion or portrayals of mental illness" (384). Additionally, Signorielli asserts that mental illness "has consistently appeared in one fifth of all primetime programs, affecting 3% of the major characters" (325). These research reports are hardly inclusive of all such studies, but they provide evidence that mental illness has a regular place in television programming.

Movies have also been the focus of much study on mental illness stigma, "dramatizing the oppressive and inhuman effects of psychiatric treatments" (Stuart 100). Stuart asserts that one in four mentally ill characters murder someone and one-half or more are depicted as harmful or dangerous (100). Additionally, he asserts that the offense rate of characters with a mental illness

as opposed to characters with no mental illness is 30 to 3 (100). Thus, it is not difficult to see that the mentally ill are often labeled as objects of fear or perpetrators of danger (99, 101).

A study by Hyler and associates categorized negative cinematic depictions of the mentally ill into several stereotype categories, including: the rebellious free spirit, the homicidal maniac, the female patient as seductress, the enlightened member of society, the narcissistic parasite and the zoo specimen (Hyler et al. 1044-1047). The study asserts that the wide range of beliefs on the treatment of mental illness is most likely due to the constantly shifting Hollywood-perpetuated stereotypes of the mentally ill (1047).

Pirkis and colleagues present two additional stereotype categories in which cinema presents the mentally ill: the simpleton and the failure/victim (Pirkis et al. 529). Baumann adds to this list, noting the frequent framing of outsider mentally ill “strangers” in an insider society, often marred by “strange... interpersonal encounter[s]” (Bauman et al. 131-133). These themes are not by any means inclusive of all representations of the mentally ill, but rather represent a broad range of scholarly categorization of media representations of the mentally ill.

These stereotypes are not only a scholarly framing. A study by Camp and associates examines the self-labeling of the mentally ill antagonist in the 2009 blockbuster, *The Dark Knight* and shows how these labels manifest on the big screen. An extension of the Batman franchise, *The Dark Knight* features Heath Ledger as the Joker. The Joker has been repeatedly framed alongside themes of madness and mental illness. In an interview with Ledger before the release of the film, he describes the Joker as a “psychopathic, mass-murdering, schizophrenic clown with zero empathy” (Lyll np). Even Paul Levitz, president and publisher of DC Comics, which published the Batman comics that eventually birthed the movie franchise, notes that the Joker “physically incarnates madness” (Cohen np).

Camp and associates examined Ledger's character in the *Dark Knight*, specifically using discourse analysis methods "informed by the understanding that producers aim to attract and hold viewers' attention" (Camp et al. 145). Through their analysis, they revealed that the mentally ill Joker was framed through a variety of methods, including language, appearance, behavior, music, technical devices and intertextuality.

Language framed Ledger's character in a variety of ways. Throughout the film, the study notes, characters, including the Joker himself, frame him in "pejorative terms: 'freak' (four times), 'clown' (four times), 'terrorist' (twice), 'strange' (once), 'mad man' (once), 'mad dog' (once), and 'a dog chasing cars' (once)" (Camp et al. 146). Another reference about the Joker's accomplice frames him as "a paranoid schizophrenic...the kind of mind that the Joker attracts" (146). Other framing includes phrases such as "he cannot be reasoned with," "murdering psychopath," and an "agent of chaos" (146).

The Joker's appearance was framed as consistently disheveled. His long green and greasy hair demonstrate his oddness along with his messy clown-like makeup. Even though his mouth is outlined in red, the scars around the corners are still quite obvious. Camp and associates also point out the constant tongue-flickering that Ledger's character demonstrates throughout the film. Various scenes show the Joker in clown masks and a nurse uniform. "[a]s the movie progresses, his appearance becomes more unconventional...[t]he changes in appearance mirror his increasingly unpredictable behaviors" (Camp et al. 146).

The Joker's behavior in the film shows both violence and destruction. He shoots others at will, causes fires, blows up buildings and is menacing to all who dare look at him. He only "appears to lose self-control toward the end; his opponents find his behavior totally unpredictable" (147). The music of the film actually frames this behavior. Camp notes that the

music each time the Joker appears is simply “two notes that clash beautifully with each other when played on the cello” (148).

Camp and associates also note that technical devices were used to demonstrate the Joker’s madness, pointing to the jump-cutting of scenes to add elements of uncertainty and instability. Additionally, they point to intertextuality such as the “mad dog” theme and the Joker’s face paint, which they claim is categorically related to “The Screaming Pope” painting of Francis Bacon (Camp et al. 148). Ultimately, the study concludes that, regardless of interpretation of *The Dark Knight*, the mentally ill Joker is framed as “otherly” and “not normal” and can serve as a valuable tool to mental health professionals as an intertextual resource for stigmatizing portrayals of the mentally ill (149).

Much research on depictions of the mentally ill in media has been discussed in the above literature. It seems logical to deduce that the media plays an important role in the formulation of public opinions on the functionality of the mental health community (Minnebo 2004; Pirkis et al. 2006). Now that a brief overview has been given on media representation of the mentally ill, it is important to discuss the standard and means by which public perceptions of the mental health community are collected. The following portion of literature will discuss known scales of measurement concerning public perceptions of the mentally ill.

### **Scales Measuring Public Attitudes Toward Mental Illness**

In an effort to produce quantifiable data, several researchers have developed workable scales that categorize and quantify public perceptions of the mental health community. The studies introduced are by no means all-inclusive but rather demonstrate highly-tested and recognized scales by which such data can be collected. Early foundational studies will be discussed as well as the adjustments made to them for future studies.

Gilbert and Levison provided a foundational assessment ideology in their 1956 study on the “ideology, personality and institutional policy in the mental hospital” (263). The study sought to:

(1) Formulate the main characteristics of the old and the newly emerging viewpoints regarding mental illness and to construct an ideology scale that will crudely measure the degree of an individual’s preference for one or the other viewpoint, (2) investigate the personality contexts within which these orientations most readily develop, (3) investigate the relationships of individual ideology and personality to membership in particular types of hospital systems and occupational statuses and (4) investigate the ways in which the hospital’s overall policy is related to the modal (most common) ideology and the modal personality of its members. (Gilbert and Levison 263)

Gilbert and Levison present the custodial-humanistic viewpoints, asserting that custodial orientations involve the “traditional prison and ‘chronic’ mental hospital which provide a highly controlled setting concerned mainly with the detention and safe-keeping of its inmates” (264); whereas humanistic viewpoints voice concern over the “individuality and human needs of both patients and personnel (264). Custodial ideologies often conceive the mentally ill in stereotypical norms and categorically different from those with no mental disease, specifically in areas of irrationality, unpredictability, and danger (264).

Humanistic viewpoints, however, are often categorized by their view of the hospital as a “therapeutic community rather than a custodial institution” (264). Interpersonal and interpsychic sources are often labeled as the foundational elements to a patient’s mental illness, and a great deal of trust is placed in the ability of the “therapeutic community” to facilitate total patient

recovery (264). It should be noted that the “concrete manifestations of humanism will differ, although the guiding spirit may be the same” (264).

The resulting Custodial Mental Illness Ideology Scale (CMI) was constructed to “test the hypothesis that a set of seemingly disparate ideas do in fact ‘go together’ to form a relatively coherent orientation in the individual” (Gilbert and Levison 264). The scale consists of 20 broadly classified statements that discuss numerous facets of the mental illness community, including nature, causes, conditions, treatment, and relational experience (264).

Perhaps one of the most-recognized methods of gathering data on the public perceptions of mental illness is the Opinions About Mental Illness (OMI) scale, developed by Cohen and Struening. The authors believe that:

[m]ental patients are sensitive to and influenced by the attitudinal atmosphere created by hospital employees...[and] the success of reintegrating former mental patients into society is affected by the attitudes of the general public toward mental illness and that these attitudes play a role in determining the support of mental health programs by the general public as voters and taxpayers. (349)

Because of this belief, Cohen and Struening attempted to identify and “develop measures of the salient dimensions underlying opinions about mental illness among hospital personnel [and] explore the construct validity of these measures by relating them to demographic characteristics of the respondents—occupation, education, age, and sex” (350). A pool of 200 opinion items referring to cause, prognosis, treatment and description of severe mental illness was developed. After receiving feedback from hospital-experienced researchers, the pool was summarized into 55 opinion statements, each developed from previous mental health scales, such

as the Custodial Mental Illness Ideology (CMI) scale (Gilbert and Levinson) and other previous work on mental illness scaling done by Struening.

The scale was distributed to personnel at two large neuropsychiatric hospitals. Results indicate five main factors of categorization in the public perceptions of mental health: authoritarianism (Cohen and Struening, 352), benevolence (352), mental hygiene ideology (353), social restrictiveness (354), and interpersonal etiology (355). Each of these factors represents competing viewpoints and perceptions on the functionality of the mental health community.

The first factor, authoritarianism, stresses the differentiation and inferiority of the mentally ill (352). Overall, participants with agreement levels regarding these categorical statements indicated their views of the mentally ill as a “class inferior to normal and requiring coercive handling” (352). In this factor, the mentally ill are grouped as a “negatively stereotyped out-group” with the same implications as many racial, religious and minority groups face in the “normal” world (352).

Benevolence, consequently, takes a “promental” stance (Cohen and Struening 353). In this factor, compassion toward patients seems to arise out of a “sort of Christian kindness toward unfortunates” (353). Participants with agreement in this category view mental patients not as “failures in life,” but rather as those that require the same responsibility as children (353). The mentally ill are still labeled as an obligation of society but are believed to receive a high quality level of care. This view still asserts that it is “dangerous to forget for a moment that they are mentally ill” (353).

The third factor, mental hygiene ideology, also takes on this pro-mental health stance, implying that mental patients are “much like normal people, differing from them in degree, but not in kind” (354). The mentally ill are still indebted to the obligations of society and are

believed to benefit greatly from proper treatment (354). Those who fall in this category tend to believe that “mental illness is an illness like any other” (354).

Social restrictiveness returns to a way of thinking that ostracizes the mentally ill. This fourth factor indicates that the mentally ill should have restricted social interaction upon release from mental health facilities, particularly for the protection of the family unit (Cohen and Struening 354). Those in this category believe that marital and familial rights of the mentally ill should be monitored or restricted, including sterilization of the patient as a precautionary method (354).

Finally, interpersonal etiology discusses the role that interpersonal interactions play in the formulation of mental diseases. There is a strong level of belief in this factor that “mental illness arises from interpersonal experience, particularly deprivation of parental love and attention during childhood” (355). Some indications are given that mental illness is motivated, but this belief is significantly less central than the role of parental and other influential interpersonal causes (355).

A foundational study in the mental health field, conducted by Taylor and Dear, birthed a scaling instrument that has been used regularly in the documentation of mental illness stigma. The Community Attitudes of the Mentally Ill (CAMI) scale was developed in an attempt to gain ultimate insight into the roles that the mentally ill are perceived to play in society (226). The study surrounding CAMI development involved an analysis of community opposition to the establishment of community mental health facilities in the metropolitan Toronto area. Taylor and Dear attempted to locate “acceptor” and “rejector” neighborhoods and establish the “planning guidelines for locating those facilities” among acceptor residents (227).

The study methodology focused specifically on two criteria. First, it was developed in a way that could differentiate between individuals that have accepting or rejection attitudes toward the mentally ill in their community. Second, it sought to measure the overall community voices on the existence of a localized mental health facility (227). Combining elements from the existing scales (including Cohen and Struening's OMI), Taylor and Dear focused their study on four specific community attitudes: authoritarianism, benevolence, social restrictiveness and community mental health ideology (229-230). These scales differed from the original methods in two main methods: first, "by their emphasis on those facets of the content domain of each scale that relate most directly to community contact with the mentally ill" (238) and second due to the wording of the studies being constructed with public versus professional knowledge of the mental health community (238-239).

Again, it must be mentioned that this list is far from all-inclusive. Rather, it seeks to present only a select few of tried-and-true study methodologies and their designs. Yet, discussing the methodologies used in previous studies is not merely sufficient. Variables associated with the study at hand often reveal rich data that is of great significance to the research study. The variables of this research study are gender and religious involvement; thus, it seems appropriate to examine how these variables have been measured in previous studies using the same or similar instruments. Additionally, the sample pool used for this study consisted of college students. Thus, studies using a similar sample pool will also be addressed.

#### *Scale Use and Integrations with Gender and Religious Involvement*

Many studies have focused on the role that variables have on perceptions of the mentally ill. These studies range in scope and each reveal different facets about the implications that various variables have on intrapersonal attitudes. Studies have shown that gender does play a

significant role while others assert that it does not. Still others claim that there is no accurate measurement of gender in perception formation and call for further research. The following portion of literature will attempt to discuss the two main variables related to this study and how they have emerged in similar studies.

Currin, Hayslip and Temple explored such perceptions by examining the way that age, gender and historical change impacted adult perceptions of mental health services. The authors examined data collected from three periods of a longitudinal study. This data from 1977, 1991 and 2000 relied upon a time-lagged design and attempted to target the impact of historical change on mental health attitudes, specifically as it relates to gender. Data was collected from three independent samples of urban, community-residing older adults in the southwest region of the United States as well as a sample of convenience from a variety of demographics (for comparisons). They collected a variety of information from a variety of different age groups: 1977 ( $N=90$ ;  $M$  age= 70.22;  $SD= 6.48$ ), 1991 ( $N= 101$ ;  $M$  age= 70.81;  $SD= 4.22$ ) and 2000 ( $N=99$ ;  $M$  age= 69.83;  $SD= 4.95$ ). Around 68% of the 1977 sample were women, as were 71% in the 1991 sample and 73% in the 2000 sample (Currin, Hayslip and Temple 323).

The authors used a 5-point likert scale to assess the breadth of conceptions about mental illness. Although slightly different in scope from CAMI assessments, the tools used by Currin and associates attempted to measure similar themes, such as perceptions of mental illness, openness to psychological mediation, professional and mental health biases and knowledge regarding the difficulties associated with mental health. The study found that women tend to have higher levels of biases and greater breadth scores scaling bias in two out of the three samples (1991, 2000). Further, women in the 2000 sample demonstrated the lowest level of positive mental health perceptions than in all of the samples among both genders. They found

that, despite these assertions, “women seem to be more advantaged attitudinally over time than are men” (Currin, Hayslip and Temple 336-337).

Albizu-Garcia and associates used perceptions of the mental health community to gauge individual’s willingness to seek help should mental health issues arise. Using two-waves of data collected from 1992-1994, the authors rely heavily on The Help-Seeking Decision Making Model adapted from previous help-seeking studies. Sampling 3504 individuals from Puerto Rico, the study relied heavily on interpreting data collected with gender closely integrated.

The study proposes that perceptions of the mental health community differ significantly between males and females. Specifically integrated with the study’s focus on help-seeking, the study found that men are not totally unwilling to seek help for mental health issues, but do so in ways that are less stigmatized, such as outpatient treatment and private counseling. All in all, the authors assert that there was a stigma associated with mental health help-seeking in a large portion of the data and that ultimately “men and women are equally likely to use services for a mental health problem when all sources of formal care are jointly considered” (Albizu-Garcia et al. 874).

Additionally, the authors assert that “gender was found to interact with significant indicators of need as well as with several of the predisposing and enabling factors that exert an effect on utilization” (874) and that in spite of men and women being equally likely to seek care, for men, “seeking mental health services requires a higher degree of morbidity and a negative perception of the status of their mental health” (875). Ultimately, the study concludes that perceptions of mental health services, even outside of the realm of help-seeking, are significantly influenced by gender.

A similar study by Ojeda and Bergstresser supports these findings. These authors measured gender against perceptions of the mentally ill as well as barriers to mental health help-seeking through data collected in the 2002 National Survey on Drug Use and Health (NSDUH) which was sponsored by the Office of Applied Statistics in the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration. The authors specifically examined three psychological themes related to mental health care: stigma avoidance, negative attitudes toward treatment and mistrust or fear of the mental health system.

The study showed that both men and women have psychological barriers to seeking help for mental health issues. Pertinent to this study, Ojeda and Bergstresser found that gender differences were statistically significant for stigma avoidance and on perceptions of the stigma. Overall, the study asserts that mental health professionals must target mental health stigma on a universal level because “overemphasizing the role of psychosocial factors as a significant mechanism underlying disparities in care may also inadvertently mask the contributions of other factors” associated with mental health stigma (Ojeda and Bergstresser 330).

Ojeda, along with McGuire, measured these assertions further in another study examining the influence of gender on help-seeking and perceptual influences of stigma toward the mental health community. The study examined depressed adults’ use of mental health services and the stigma surrounding such activity. Ojeda and McGuire argue that “[d]epression is one of the most commonly diagnosed mental health conditions and prevalence rates vary by gender and race/ethnicity” (Ojeda and McGuire 211). The authors use data collected from the 1997-1998 wave of the Healthcare for Communities Survey (HCC), and re-interviewed over 9600 adults who had previously participated in the survey. The study concluded that mental illness, specifically depression, is evident in both men and women and is not as highly stigmatized as

other mental diseases. Overall, the study finds that more research is needed to examine the stigma associated with various mental disease levels and how gender influences perceptions of those levels.

An Australian study from Reavley and Jorm examines the role of gender in stigmatizing attitudes toward the mentally ill. Using 6019 phone interviews from 2011, the authors presented participants with a case-study vignette dealing with a mentally ill character. After presented with the vignette, participants discussed their opinions with the researchers. Stigmatizing attitudes were assessed via two sets of statements. One attempted to assess the respondents' personal attitudes and perceptions toward the character in the vignette and another attempted to assess their perceptions of the attitudes that others might have.

The study used a likert scale-type assessment to measure these. Self-stigma was measured via the following statements:

(1) People with a problem like John/Jenny's could snap out of it if they wanted, (2) A problem like John/Jenny's is a sign of personal weakness, (3) John/Jenny's problem is not a real medical illness, (4) People with a problem like John/Jenny's are dangerous, (5) It is best to avoid people with a problem like John/Jenny's so that you don't develop this problem, (6) People with a problem like John/Jenny's are unpredictable, (7) If I had a problem like John/Jenny's I would not tell anyone, (8) I would not employ someone if I knew they had a problem like John/Jenny's and (6) I would not vote for a politician if I knew they had suffered a problem like John/Jenny's.  
(Reavley and Jorm 1087)

The stigmatizing attitudes of others were measured in a similar way with the prefix “Most other people believe that...” (1087). The study also employed a social distance-type scale with a 4-point likert scale assessment of individuals’ willingness to: “(1) move next door to John/Jenny, (2) spend an evening socializing with John/Jenny, (3) make friends with John/Jenny, (4) work closely with John/Jenny on a job and (5) have John/Jenny marry into their family” (Reavley and Jorn 1087).

Results did not yield significance for gendered perceptions but did interestingly show that vignettes that dealt with a male character (“John”) were typically “more likely to be seen as dangerous” (1092) by women. Additionally, all participants indicated higher levels of social distance from the mentally ill male characters over the mentally ill female characters, most likely due to the perceived danger of men as demonstrated in the vignettes. Ultimately of value to gendered examinations of perceptions and the mental health community is the authors’ assertion that “anti-stigma interventions are more likely to be successful if they focus on individual disorders rather than on ‘mental illness’ in general” (1086). The authors assert that a focus on individual diseases may reveal more about gender influence, much like results indicate the perceived level of danger of male mental patients.

Gordan and associates examined attitudes on interpersonal relationships with mentally ill and mentally retarded persons. Using a sample of 218 undergraduate students from a Midwestern university, the authors attempted to measure the influence that gender has in perception formation. Participants were asked to indicate their knowledge about and association with 13 distinct disability populations as well as complete a Bogardus social distance scale.

Results indicate that participants had a largely stigmatized view of relationships with mentally ill individuals. First, individuals indicated that they had little to no desire to be “regular

friends” with persons with mental health issues or those that are mentally retarded. Additionally, gender proved to be significant in knowledge about mental illness, with females reporting higher levels of factual knowledge. Gender was also significant, albeit on a modest level, on scores for the desired level of social distance with a mentally ill population, with men reporting a greater desire of social distance than females.

Overall, Gordan and associates determine that, regardless of the competing views about the influence of gender in perceptions of the mentally ill, gender proved to be significant in this study and should be given consideration on future studies that focus on interpersonal relationships with the mentally ill. Specifically, women reported having greater knowledge about mental illness and were more comfortable in interactions with the mentally ill than men. The study concludes that there is a “critical issue regarding the need for greater education, particularly about those disabilities most at risk for stigma” (Gordan et al. 54).

Jackson and Heatherington examined perceptions of the mentally ill in a young, Jamaican population. The authors first used a videotaped job interview of a teacher whose history was altered. One copy of the tape framed the teacher as having previous issues with mental health while the other copy had no references of mental health. The study used a Social Contact Scale (similar to a Bogardus social distance scale), as well as Cohen and Struening’s 1963 Opinions About Mental Illness Scale (OMI).

When coded for gender, results showed that overall, female participants had the highest level of desired contact with normal male job candidates, while both male and female participants desired similar levels of contact with normal female job candidates. Both male and female participants’ desire for contact “dropped off when the job candidate was described as

having a history of mental illness” (Jackson and Heatherington 569). Further, females indicated the greatest distance in desired contact with the mentally ill male character.

Additionally, the study found that there was a significant influence of gender, in that “female students endorsed stronger attitudes about mental illness as a failure of will than did male students” (570). There was also a significant gendered revelation, in that male participants endorsed benevolence factors of the OMI at a higher rate than females. Ultimately, however, the study concludes that “in contrast to other findings, [there were] no found [significant] effects of gender on the amount of social contact desired with the job candidate, nor did the gender of the job candidate make a difference” (571).

Phelan and Basow examined yet another college student population. Surveying 168 undergraduate students from a small, Northeastern liberal arts college, Phelan and Basow used three vignettes to test perceptions. One vignette featured a character with an alcohol addiction, another with major depression and one with common stress. Participants were asked to assess the dangerousness of the characters by responding to three questions, including “How likely is it that [name] would do something violent toward other people?” and “How likely is it that [name] would do something violent toward himself/herself?” The third question asked participants to rank the level of dangerousness on a 6-point likert scale with 1 being *not at all dangerous* and 6 being *extremely dangerous* (Phelan and Basow 2885).

The authors also instructed the participants to provide a label for the character in the vignette as mentally ill or not mentally ill as well as complete a scale attempting to measure their familiarity with mental illness. Additionally, the authors used a Bogardus Social Distance Scale to measure participants’ desired levels of willing association. In addition to several other small-

scale questions, participants were asked to complete the short form Hypergender Ideology Scale to assess participants' adherence to traditional gender roles.

Results from the study showed that “labeling predicted an increase in negative stereotyping, and negative stereotyping increased discrimination” (Philan and Basow 2894). The study found that when participants assigned a “mentally ill” label to the characters, perceptions of danger increased, as did desires for greater amounts of social distance. Phil and Basow also found that gender was significantly related to perceptions of danger and desire for social distance. Overall, male target characters were perceived to be more dangerous, and were tolerated less than female target characters. Additionally, participants desired greater social distance from male target characters. The authors assert that this is most likely due to the ideology that “mental illness is still seen as more taboo for men...[and] men are much less willing than women to seek help for mental health issues” (2895).

A study by an Angermeyer, Matschinger and Holzinger utilized Taylor and Dear's Community Attitudes Toward the Mentally Ill (CAMI) assessment in a German population. Their results indicate that, compared to the American sample used by Taylor and Dear, “at the item level, surprisingly positive attitudes toward people with mental illness were found” (Angermeyer et al. 202). They found that age had a largely negative impact on perceptions of the mentally ill. Additionally, they reported that women showed higher levels of anxiety in relation to the mentally ill and that they often demonstrated more “pro-social” reactions than men (204-205). Social distance, in this study, was often more pronounced by men than it was from women, yet the study concluded that gender was not a significant influent in determining social distance or in participants' perceptions of the mentally ill.

Hinkelman and Granello examine several variables related to gendered perceptions in their study on perceptions of the mentally ill, namely biological sex, adherence to traditional gender roles and their integration with mental illness. In their sample of 86 undergraduate students, participants completed Taylor and Dear's CAMI assessment as well as the Hypergender Ideology Scale, which measured their degree of adherence to traditional gender roles. The study's results show that, much like previous research, "males scored in a less tolerant direction on two of the four CAMI subscales (Benevolence and Social Restrictiveness)" (Hinkelman and Granello 267).

Additionally, in response to their second hypothesis, the authors found that "biological sex was not significantly related to tolerance when hypergender ideology was controlled for... Thus, adherence to hypergender ideology, rather than biological sex, was related to attitudes toward persons with mental illnesses" (267). The authors use their findings to argue that far more research must be done to examine the true variables of biological sex and gender roles.

Adeyuya and Makanjuola examined the desired level of social distance towards people with mental illnesses in a Nigerian university student population. The authors used a Bogardus Social Distance Scale that was distributed to 1668 respondents. Results of this study in a Nigerian population showed that there is a "moderate level" of social distance among Nigerian students. Overall, 79% percent indicated that they would not be willing to marry someone with a mental illness while 64.5% would not be comfortable even sharing a room with a mentally ill individual (Adeyuya and Makanjuola 867-868). Results indicated that participants' sex was significantly associated with high social distance, with females reporting a higher desired level of social distance than males (868). The authors note that this is consistent with other findings, noting that females in Hong Kong, other African and even Western populations report high

desired levels of social distance, because, as the authors assert, “men are expected to be outwardly braver than women” (868).

Interestingly, Adewuya and Makanjuola also examined the role of religion in their study. Among their sampled population, 55% reported to be Christians ( $N= 917$ ), while 43% were Muslims ( $N= 719$ ). The remaining population was not religiously involved. The authors found that through chi-square and Kruskal-Wallis tests, religion did not emerge as a significant variable; thus, it was not discussed in the results or discussion section. This is one of very few studies that even touch on religion and religious influence on perceptions of the mentally ill.

Silton and associates briefly touch on religion in their overview of perceptions of mental illness and desire for social distance from 1996 and 2006. The authors used data collected from the 1996 and 2006 General Social Surveys (GSS) from 1152 participants in 1996 and 1412 participants in 2006. The study involved scales that measured participants' thoughts of the dangerousness of the mentally ill as well as a social distance scale. The study reveals several interesting themes related to religious influence. First, the 1996 survey showed that “participants who espoused a religious affiliation were more likely than unaffiliated participants to assert that persons with mental illness should be treated against their will” (Silton et al. 362).

The study also found, however, that female participants and those that attended religious services more frequently were less likely to perceive a person as mentally ill than other participants (364). Participants that attended religious services more frequently “exhibited significantly less of a desire for social distance than did those who attended less frequently” (364). The study ultimately concludes that “participants who were younger, white, better educated and attended religious services more often” had lower amounts of stigma and desired levels of social distance (361).

Chung and Chan also briefly touched on religious involvement in their study focused on a Chinese undergraduate population. The study utilized vignettes, based off of the 1996 General Social Surveys (GSS) that were also used by Siltan and associates. Participants were given methodological tools to scale their desired level of association with the characters in the vignettes as well as one to mark their overall perceptions of them. Overall, the study concluded that young Chinese adults “did not endorse negative views about people with mental illness” and that (513) “students with religious beliefs were more accepting toward the target individual associated with [a] diagnostic label than one with no labeling” (507).

These two studies alone are the only studies found that use religious beliefs, involvement and identification as variables in studies that deal with perceptions of the mentally ill. These studies also recognize that previous studies have not touched on this topic, evidenced by their lack of discussion on it through literature review and citation. It is baffling to think that few scholars have examined the impact that religion has on perceptions of the mentally ill. Religion has been used to study perceptions of many entities, including science (Scheitle), gerontology (Krause), aesthetics (Guggenmos et al.), culture (Grigoropoulou and Chrysochoou), healthcare (Maltby et al.), personality changes (Halama et al.), other religions (Boaz; Ellor and McFadden; Karuvelil) and a variety of other themes. Thus, it seems pertinent to examine how religion and religious involvement impacts perceptions of the mentally ill, which is the theme of this study.

To do this, however, a strong theoretical framework must be adopted. It is not merely sufficient to gauge perceptions with no guiding way to interpret those results. The next portion of literature will attempt to reveal the intricacies of Sherif’s Social Judgment Theory, its implications and discuss why it is an appropriate framework to adopt for studies dealing with perceptions of the mentally ill.

## Social Judgment Theory

Within the field of social sciences, much effort has been given to the development of assessment tools for attitudes and perceptions. Aside from many studies already mentioned in this review, other significant studies exist that have attempted to categorize the phenomenon of human judgment (Edwards; Guilford; Katz et al.; Remmers; Riley et al.; Sherif and Hovland; Sherif and Sherif; Torgerson).

It is this very human judgment that creates and maintains reality for those living “outsider” roles, such as the mental health community (Baumann 131). Because of this, it is important to establish a specific theoretical framework by which more research can be conducted on public attitudes toward mental illness. Muzafer Sherif’s Social Judgment Theory provides an excellent working methodology for research.

Sherif’s theory deals specifically with conviction that:

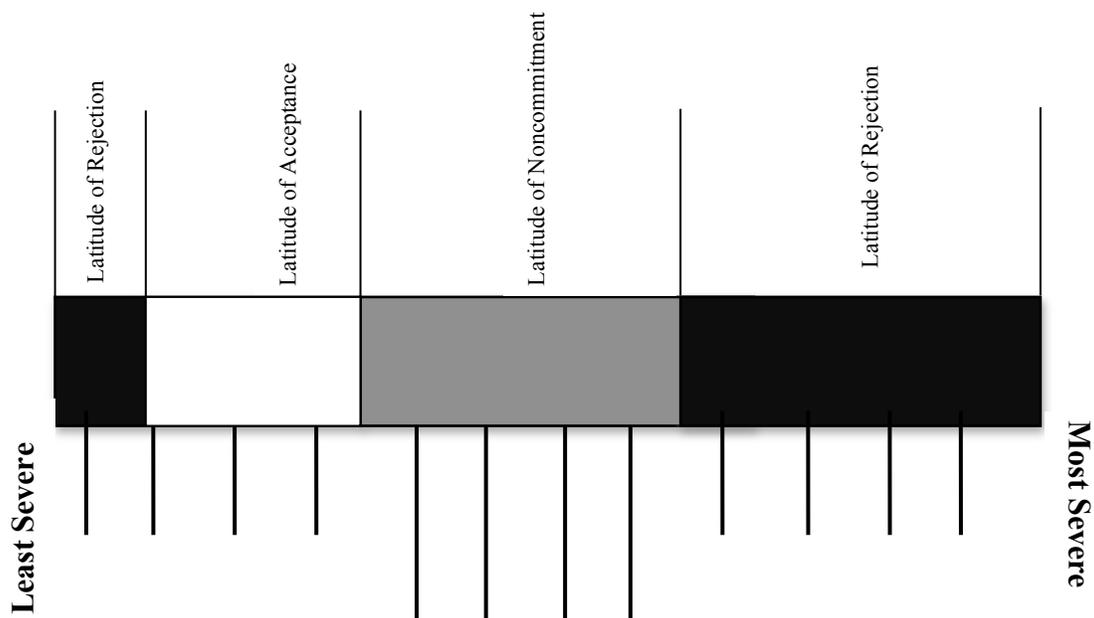
An individual’s stand toward other people, groups or social issues is *not* adequately reflected by a single alternative or position among those ... An individual’s attitude on an issue can be assessed adequately only if the procedures yield the limits of the positions he accepts (latitude of acceptance) and the limits of the positions he rejects (latitude of rejection), relative to the bounds of available alternatives defined by the extreme positions on the issue. (Sherif, Sherif and Nebergall 3)

Sherif’s theory also expresses a need for provision to determine if any alternatives exist to which the individual may be unwilling to commit as “favorably or unfavorably disposed under the circumstances” (3). This facet of Social Judgment Theory, known as the latitude of noncommitment, is a defining feature that distinguishes the theory from others. Sherif asserts

that in order to flee from the dilemma of “science by analogy,” researchers must assess attitudes in a way that does not revolve solely around polar extremes (4).

Em Griffin presents a visual graphic that more adequately demonstrates the true scope of Social Judgment Theory. This graphic, as shown below, scales statements in relation to other statements. Statements provide both negative and positive-leaning statements. Essentially, they offer pre-existing opinions on the issue at hand. Social Judgment Theory relies on these opinion because participants must scale them in range of most committed to least committed with areas of non-commitment falling in the middle (Griffin 188)

**Table 1.T**  
**Social Judgment Theory Chart**



Before discussing Social Judgment Theory in greater detail and application, it is important to note the theory is deeply connected to the idea of attitude. Attitudes “refer to the stands the individual upholds and cherishes about objects, issues, persons, groups or institutions” (Sherif, Sherif and Nebergall 4). These attitudes constitute an individual’s worldview, by which

elements such as morality, ethics, religion, family, and a variety of other characteristics are analyzed. It must be noted that labeling attitudes as “learned implies neither mechanical imprinting nor formal instruction...” (5). Rather, part of the human development involves labeling objects, persons or groups in “approving, disapproving, or other affective tones” (5). As these labels are formed, the labeler formulates desires of acceptance and belonging. Once accepted (or rejected), the individual begins to form identity based on involvement with the selected group.

On this basis, Sherif asserts that “[s]ocial attitudes, therefore, have motivational and emotional properties” (5). Thus, these attitudes ultimately have an influence over the acceptance, rejection and stigmatization of others. Attitudes are ultimately a core facet in the process of determining whether or not outsider individuals meet a specific level of criteria (as established by the identity group) in order to be accepted into the in-group. Attitudes are the core of accepting or rejecting messages of all types, including social stigma.

One of Social Judgment Theory’s central claims involves the assertion that “[p]lacement of communication as within, near to, or far from the bounds of acceptability is the crucial process underlying attitude change, including direction and amount of attitude change” (227). Kiesler, Collins and Miller reword this assertion in the following two-fold hypothesis:

In our interpretation, the theory explicitly views attitude change as a two-stage process. First, one makes a judgment about the position of the persuasive communication relative to one’s own position. Attitude change occurs after this categorization or judgment. The amount of attitude change depends on the judged discrepancy between the communication and the respondent’s own position (240).

A 1966 study by Bochner and Insko examined Sherif's theory from a different angle. The researchers attempted to pattern their study after similar methodologies that have "manipulated the communicator-communicatee discrepancy [and] found an increasing linear relation with influence" (614). A sample pool of students was surveyed to gain a gauge by which the perceived appropriate amount of sleep could be measured. After receiving results, the researchers formulated a booklet of written communication advocating for the appropriate number of hours of sleep, ranging from zero to eight (615-617). Opinion change was found to be "linearly related to communicator-communicatee discrepancy for high credibility source and curvilinearly related to communicator-communicatee discrepancy for a medium credibility source" (614, 619-621).

Wigton used Social Judgment Theory to assess the attitudes behind medical judgments. He states that the "Social Judgment Theory approach is well suited to studying medical judgment. Many of the day-to-day tasks of physicians involve making decisions under uncertainty requiring the evaluation of multiple fallible cues" (175). Wigton makes an argument that Social Judgment plays a role in many of the everyday tasks of physicians, including diagnostics, therapy, prognosis, and decisions involving medical tests (176-177). The study makes an appeal for more research to be done using Social Judgment Theory-type methodologies in order to increase the overall understanding of the judgment process (188).

A final view into Social Judgment Theory is given by communication scholars McCroskey and Burgoon in a 1974 study. This research team attempted to analyze between two opposing deductions on judgments. As Social Judgment Theory asserts, "people have varying degrees of acceptance-rejection of sources and concepts that depend on who the source is and what the topic of communication happens to be" (421). An opposing theoretical proposition given by Rokeach, however, asserts that "people evaluate sources and concepts without regard to

topic [suggesting] that people have an enduring personality syndrome that predicts how open or accepting they are of concepts and people in general” (qtd. in McCroskey and Burgoon 421).

To test these opposing views, McCroskey and Burgoon surveyed 98 undergraduate students at Michigan State University. Subjects were instructed to react to ten topics on six, seven-interval semantic differential-type scales (422). Topics varied on themes of political conservatism and liberalism. For each topic, latitudes of acceptance, rejection and attitude were computed. Results indicate that the “original assumption posited by Social Judgment Theory that latitudes of acceptance-rejection and attitude intensity are topic-specific” are questionable (425). Subjects appeared to demonstrate that “people have relatively invariant widths of latitudes of acceptance and rejection across topics and sources” (425). Additionally, intensity of displayed attitudes does not seem plausibly linked to specific topic, but rather is a trait evident across topic spectrum (425-426).

### **Conclusion**

The previous literature has attempted to guide through the vast array of research that exists on four distinct topics. First, literature examined the versatility and susceptibility of mental illness and the importance of shared creation of meaning and sensemaking for those who are closely integrated to the mental health community. Second, scope was given into the various studies that have examined representative depictions of the mentally ill in both fictional and non-fictional media. Third, valid forms of perception measurement were discussed, with emphasis given to the implications and limitations of each. Finally, a theoretical framework for this study was provided by examination into Sherif’s Social Judgment Theory.

The purpose of this study is to add to the already voluminous research on public perceptions of the mental health community by incorporating a new theoretical framework. It is

important to note that research on this topic is already substantial and abundant, thus this study will not attempt to provide unnecessary data or discussion. Its ultimate purpose is to interpret perceptions under the guiding theoretical framework of Sherif's Social Judgment Theory. The following research methodology details the steps taken to incorporate this theoretical frame, as well as discusses the specific course of action taken to yield research results.

### Chapter 3- Methodology

The research reviewed above has examined a vast amount of studies that have been conducted using variables related to the mental health community in an attempt to gain perspective into overarching social perceptions of the mentally ill. Numerous qualitative studies abound that discuss media representations of mentally disabled individuals; yet, many do not take the extra step needed to evoke change. The following methodology attempts to explore how previously discussed methodological instruments used to measure public perceptions of the mentally ill will be used for this research study.

Throughout the course of this study, the fueling questions of inquiry were as follows: (1) do the perceptions of college students regarding the mental health community reveal any statistically significant themes? and (2) does level of religious involvement play any major role in the self-admitted perceptions of the mentally ill? The formal research questions of this study are threefold:

**(RQ1)** What are the latitudes of acceptance, rejection and non-commitment that college students identify in their perceptions of the mental health community?

**(RQ2)** Does gender influence college student perceptions of the mentally ill?

**(RQ3)** Does the level of religious involvement that college students identify correlate to their perceptions of the mentally ill?

The following review of methodological procedures will discuss four key areas: (1) research strategies and methods used for this study, (2) research instruments, (3) data analysis techniques and (4) validation procedures.

## **Strategies and Methods**

Because of the vast exploration of qualitative data surrounding this subject, as well as the complex variables that fuel its research inquiry, quantitative means were first selected as the framework of data collection to be used. Wolstenholme notes that, historically speaking, “quantitative models are essential for understanding the dynamics of complex systems” (422). Additionally, Cheek and associates posit that since quantitative methods have had historical domination in research, those who read and further analyze research studies will have “long experience and familiarity with quantitative approaches as opposed to qualitative ones” (147). Thus, in an effort to add relevant research to the voluminous amount of literature on this topic, and in an effort to maintain the intended validity of methodological instruments, a qualitative method of analysis was used in this research study.

### *Overview of Research Method*

This research study used a survey-design because it contributes toward the goal of collecting large amounts of complex quantifiable data without compromising the researcher’s intent or research design structure. Additionally, the use of surveys allows for the collection of data from a population that would be difficult to study in a laboratorial setting, especially given the nature of the topic of study. Demographic information was collected to assure that participants met several key requirements pertinent to the study (see Appendix A). Several established surveys were used to measure perceptions of mental illness. These surveys include Taylor and Dear’s Community Attitudes of the Mentally Ill (CAMI) scale (see Appendix B) and Bogardus’ Social Distance Scale, adapted to those within the mental health community (see Appendix C).

Research participants were sampled from a large, private mid-Atlantic, faith-based university. The university selected for sampling has strong ties to the religious community and operates out of a Southern Baptist theological standpoint. The university requires all students to attend three, religiously-themed convocation services per week, thus it is an appropriate institution to collect information based on variables of religious involvement. Participants were selected via a sample of convenience using a large lecture-format communication course. All participants completed surveys at will and received extra credit points in their communication course for completing the online assessment. Surveys were administered during January and February of 2012. All research methods and participant requirements were detailed in the application to the Institutional Review Board (IRB), and full IRB approval was awarded to this study before data collection. To safeguard participants, informed consent forms (see Appendix E) were made available. All participants were notified via writing of the potential risks associated with the study.

#### *Demographic Questionnaire*

First, in order to determine overall eligibility for the study, a demographic questionnaire was distributed to all participants. This brief survey assessed participants' gender, age, level of education, political affiliation, religion of choice and level of religious involvement. Additional variables, such as ethnicity, religious-denominational affiliation and relationships with a mentally ill person were also included to determine if additional variables would have an impact on results.

To be eligible for the study, participants were required to be currently enrolled as a student with at least 9 registered credit hours and be between the ages of 18-35. Participants were also required to indicate their political party affiliation as one of the following: Democrat,

Independent, Republican or Other. Political parties were listed in alphabetical order in an effort to eliminate any trace of researcher bias toward a particular political affiliation.

Participants were invited to select their religious affiliation from the following options: agnosticism, atheism, Buddhism, Catholicism, Christianity, Hinduism, Islam, Judaism, Paganism, Unitarian Universalist, or Other. Additionally, participants were asked to indicate their religiously-affiliated denominational preference in an open-ended format. These open-ended responses were grouped and coded into fourteen (14) separate categories.

Religious involvement was measured as well. Participants were instructed to select one of the following statements that most closely mirrored their religious activity: (1) I willingly attend two or more religious services per week (non-required services), (2) I willingly attend one religious service per week (non-required services), (3) I attend one or more required religious services per week or attend other religious activities sporadically, (4) I occasionally attend a religious service, or (5) I am not religiously involved. To be clear, a required religious service was relevant to the surveyed population due to a required convocation service that occurred three times per week at the location surveyed.

Finally, participants were asked if they had a relationship with anybody with a diagnosed mental disease. This is the only time that the study included delineation between diagnosed and undiagnosed mental diseases. This delineation was used to help narrow down perception sets by providing a firm anchor to weigh relationships. If participants did have a relationship to such a person, they were asked to categorize their relationship as one of the following: (1) immediate family, (2) non-immediate family, (3) close friend, (4) acquaintance, (5) distant social relationship or (6) undisclosed.

*Community Attitudes of the Mentally Ill (CAMI) Scale*

Taylor and Dear adapted previous scales in an attempt to focus their research on specific community attitudes toward the mental health community. Ideas of authoritarianism, benevolence, social restrictiveness and community mental health ideology were examined through the general public's point of view, making this one of the first research studies to examine the mental health community through the public rather than professional lens (229-230; 238-239).

As mentioned, authoritarianism, benevolence, social restrictiveness and community mental health ideology served as four distinct scales of measurement. A total of 40 statements comprised the CAMI test, with 33 statements being exclusive to Taylor and Dear's study and 7 belonging to existing OMI, CMI and CMHI scales used to assess mental health perceptions (228). Essentially, the CAMI assessment was birthed out of these various, previously-existing scales and uses 7 statements from those assessments in its questionnaire. Each of the four scales consisted of ten statements each, with a likert scale of measurement used to assess participant level of agreement for each statement as strongly agree, agree, neutral, disagree, strongly disagree.

Five of the ten statements on each scale were expressed in a positive method with reference to the underlying conceptual framework while the other five were negatively referenced. For example, per each of the four scales, five of the ten statements expressed a pro-scale sentiment while the other five represented an anti-scale sentiment (229). Additionally, all statements were presented in a sequence of ten sets of four. Within each sequence, statements were ordered by scale in order to "minimize possibilities of response set bias" (229).

While the CAMI scale has been involved in many research studies (Barke et al. ; Gilbert and Strong; Högberg et al. ; Vibha), few have examined any variables similar to this research study. Hinkelman and Granello provide the only known study that focuses on college-aged participants with another variable when examining the CAMI test. This study involved undergraduate participants that responded to both the CAMI test and The Hypergender Ideology Scale, which sought to measure “the degree to which they adhered to traditional gender roles” (259). Ultimately, the study determined that strict gender-role identification and adherence, as opposed to biological sex, accounted for any variance in the CAMI scales.

Taylor and Dear’s CAMI scale was used for this research study with no alteration in order to collect similar quantifiable data from participants. It was used in an effort to gain a base knowledge and understanding of participants’ perceptions of the mental health community with no aspect of the scale being altered to include a variable influence. It provides a simple yet broad range of situational perceptions in an attempt to provide the researcher with a wide range of possible perspectives and influences on perceptions of the mental health community. It alone, however, is not sufficient because it only assesses established statements about the mentally ill and does not specifically identify the level of comfortable association that individuals would have with the mentally ill. Social distance is an important aspect to gauge, especially given the communication-themed nature of the study. Thus, participants were also asked to complete a social distance scale, assessing their preferred level of contact with the mentally ill.

#### *Bogardus Social Distance Scale*

Emory Bogardus developed the Bogardus Social Distance Scale in an effort to empirically measure individuals’ willingness to be associated with a specific demographic or diverse social group, such as those from other ethnic groups, criminals, homosexuals or a various array of other

phenomena. As indicated by Bogardus himself, feelings often reveal human acceptance and rejection “better than any other approach. Social distance tests disclose these reactions in their simplest, crudest and purest forms” (307). Thus, the intent of the social distance scale is to measure human perceptions or prejudices about a particular social group.

The scale itself is brief, including only seven assessments. Participants are instructed to answer the question with a specific target audience in mind. They must indicate their preferred level of social proximity to the specific audience provided. Intimacy ranged from simple nationality-similarities to marital ties. Scores are assessed in a likert style, yet the Bogardus Social Distance scale is an example of a Guttman scale, meaning that it is cumulative and unidimensional (Wark and Galliher 392). It is unidimensional because itemized scale statements can only be used to measure a single theoretical concept. Items are placed on a continuum, leading to the cumulative nature of the scale. If the scale items are in ascending order (item one indicates low intimacy and item seven indicates high intimacy), a participant that accepts a given degree of intimacy, they will also accept a lower degree of intimacy. If they reject a low form of intimacy, they are also likely to reject higher forms of intimacy (392-393).

The Bogardus Social Distance Scale has been used in a variety of contexts. Studies highlight the social distance preferred between society and sex offenders (Shechory and Idisis), homosexuals (Staats; Steffensmeier and Steffensmeier), various ethnic groups (Derbyshire and Brody; Horak et al. ; Morgan), religious groups (Brinkerhoff and Jacob) and even the mental health community (Bell; Parra; Volmer). This scale will be used in a similar fashion for this research study. The object of perceptual interest is the mental health community, or those that have a diagnosed mental health illness (as defined on the survey). Participants will indicate their preferred degrees of intimacy with the mental health community in contrast to (1) cancer

patients, (2) convicted felons, (3) people living with HIV/AIDS, and (4) illegal immigrants.

These four comparative categories were birthed out of previous studies using the Social Distance Scale (Morgan; Parra; Shechory and Idisis; Staats; Volmer).

### *Data Analysis*

Because no new methods of quantitative data collection were created for sake of this study, results submitted were interpreted and coded under the original guidelines and categories of each survey's study of intent. No new themes or categories were presented in any submitted questionnaires or surveys, with the only variable being the target audience of reaction or perception-affiliation (the mental health community). All results, ranging from demographics to research tools, were coded numerically into an Excel spreadsheet. As discussed, open-ended responses were numerically coded and placed into the appropriate categories. This spreadsheet was then coded into SPSS data analysis format.

In an effort to respect human privacy yet retain original data, quantitative surveys were filed into a private, locked filing cabinet. Themes and researcher notes were compiled into a password protected Microsoft Word document for final analysis. Original notes were destroyed. All original data pertaining to this research study will be permanently destroyed in January 2017 (five years from this study's publication).

### *Conclusion*

The section following this research methodology details the results and findings of the study and attempts to answer to fueling research questions surrounding this study: (1) what are the latitudes of acceptance, rejection and non-commitment that college students identify in their perceptions of the mental health community? (2) does gender influence college student

perceptions of the mentally ill? and (3) does the level of religious involvement that college students identify correlate to their perceptions of the mentally ill?

## Chapter 4- Results and Findings

The variables examined in this research study were gathered, as stated, via the responses of online surveys to individuals that were currently enrolled in 9 or more credit hours in a college program. The online survey was made available to more than 500 participants. For this study, a total of 257 individuals chose to participate, generating a total of 252 usable responses. Of these individuals, 114 were male (45.2%) and 138 were female (54.8%). As mentioned, ages ranged from 18-35 ( $M=20.957$ ,  $SD= 1.411$ ). Participants indicated a wide variety of ethnicity including American Indian/Native American ( $N=2$ , 0.8%), Black/African American ( $N=15$ , 6.0%), Hispanic/Latino ( $N=12$ , 4.8%), White/Caucasian ( $N=198$ , 78.9%), Pacific Islander ( $N=2$ , 0.8%) and Other ( $N=22$ , 8.8%).

Educational status was somewhat clustered, most likely due to the introductory course in which this survey was distributed. Freshmen ( $N=193$ , 76.6%), sophomores ( $N=38$ , 15.1%), juniors ( $N=17$ , 6.7%) and seniors ( $N=4$ , 1.6%) all contributed to this study. Most participants in the original sample ( $N=252$ , 98.1%) were enrolled in 9 or more credit hours, thus making them eligible to participate in the survey. Five respondents from the 257 person participant sample (1.9%) were currently enrolled in fewer than nine credit hours making their surveys ineligible to use, ultimately generating a sample of 252 usable, completed survey questionnaires. Remaining statistical data were analyzed according to the original procedures of the research tools used and the guiding research questions of this research study. For this study, statistical significance is less than .05. In the following chapter, results and findings are discussed in light of the research questions that guide this study.

*Variable Analysis*

As mentioned, participants were instructed to provide a variety of different information about their backgrounds in order to help understand possible variables that may influence perceptions of the mental health community. Participants were asked to indicate their political affiliation. Responses included Democrats (N=8, 3.2%), Republicans (N=174, 69.0%), Third Party (N=10, 4.0%) and N/A (N=60, 23.8%). Other significant variables measured were themes relative to religion and religious status. Participants were instructed to indicate their religious affiliation. Responses show that most participants (N=247, 98.0%) identify Christianity as their religion of choice. Others included agnosticism (N=1, 0.4%), atheism (N=2, 0.8%), and Catholicism (N=2, 0.8%).

In addition to providing their religious affiliation, participants were asked to provide their preferred denominational affiliation. In this open-ended question, participants indicated a variety of results. In order to adequately account for these open-ended responses in statistical analysis, results were coded into numerical groups for similar status. These included Baptist (N=86), Charismatic (N=10), Wesleyan (N=7), Evangelical (N=16), Presbyterian (N=6), Mennonite (N=1), Nondenominational (N=25), Protestant (N=2), Catholic (N=1), Nazarene (N=1), Non-Specific/Multiple (N=6), Calvary Chapel (N=2) and N/A (N=89). It was determined that, even though the ranges for denomination are wide, denomination is an important aspect of religious life, specifically among Christianity. Although religious leaders expect the importance of denomination to wane in the upcoming decades, 76% of leaders polled consider denominational affiliation a vital part of their religious journey (Roach). Thus, in an effort to find statistical significance, denomination was examined.

When asked to scale their level of religious involvement, participants indicated a wide variety of responses. It is important to note that religious involvement was measured by the level of participation participants had in religious services. There are other ways to measure involvement, but in order to be clear and succinct, participation was used as the gauge for this study. Many participants indicated that they willingly attend two or more non-required religious services per week (N=137, 54.4%) or they willingly attend one non-required religious service per week (N=75, 29.8%). Others stated that they only attend required religious services or attend outside religious services sporadically (N=17, 6.7%) or that they only occasionally attend any sort of religious service (N=17, 6.7%). The remaining participants indicated that they are not religiously involved (N=6, 2.4%).

When asked to discuss their relationship to any persons with a diagnosed mental disease, about half (N=118, 46.8%) indicated that they did, in fact, have a relationship with such persons while 128 (50.8%) indicated no known relationships with the mentally ill and the remaining (N=6, 2.4%) not disclosing any relationships. These numbers may be potentially different, however, given participants' subsequent relationship categorization. Most (N=99, 39.29%) did not categorize any such relationship. Others, (N=153, 60.71%) categorized their relationship with a mentally ill person into one of the predetermined categories. Participants indicated a wide variety of relationships with the mentally ill, including their immediate family (N=30, 19.6%), non-immediate or extended family (N=32, 20.9%), close friendships (N=23, 15.0%), acquaintances (N=28, 18.3%), distant social relationships (N=4, 2.6%) and undisclosed (N=36, 23.5%).

*Bogardus Social Distance Scale*

Once completing the demographic portion of the survey, participants were then asked to quantify their preferred relationships with the mentally ill. To measure this, participants first completed a social distance scale, which asked them to indicate their most desired social relationship with several social groups. These groups included cancer patients, convicted felons, people living with HIV/AIDS, illegal immigrants and the mentally ill. Participants were asked to select the option that best described their desired association with each of these groups, including expulsion from their country, as visitors in their country, as citizens in their country, as co-workers in the same occupation, as neighbors on the same street, as close personal friends or as close relatives by marriage.

Initially, the survey was structured in a way that yielded 35 different result patterns because participants were not forbidden to enter more than one associative level per people group. Participants thus had the option to (and did) select multiple levels for the same people group, yielding a significant number of results. These results were into coded into a Guttman scale format. As previously discussed, Social Distance scales closely model Guttman scales, meaning they are cumulative and unidimensional (Wark and Galliher 392). First, they are unidimensional because itemized scale statements can only be used to measure a single theoretical concept. Items are placed on a continuum, leading the cumulative nature of the scale. If the scale items are in ascending order (item one indicates low intimacy and item seven indicates high intimacy), a participant that accepts a given degree of intimacy, they will also accept a lower degree of intimacy. If they reject a low form of intimacy, they are also likely to reject higher forms of intimacy (392-393).

Failure of the researcher to properly account for the one-dimensional nature of the scale will be further addressed in the following chapter. The scales' results were coded numerically and sorted by the identification number of participants. Participants that selected multiple options for people groups were coded separately. These results were then truncated via the selection of the most intimate association (in keeping with the directions to the participants that asked them to "[p]lease indicate your level of comfortable association with each people group mentioned below"). In keeping with the design of Guttman scales, these truncated results allowed for greater insight into participants desired relationships and assumed that their desired level of association would also indicate their willingness to be associated with other less intimate forms of association.

Results showed a variety of preferred associations with the given people groups. For cancer patients, 219 participants (86.90%) selected their preferential relationship. Only one person (0.46%) indicated they would exclude cancer patients from their country. One said they would only be comfortable for cancer patients to be visitors in their country, one as citizens in their country and one as co-workers in the same occupation (0.46% respectively). Some indicated that they would be only comfortable as neighbors on the same street (N=8, 3.65%) while others indicated they would be comfortable with a close friendship to a cancer patient (N=46, 21.00%). Most (N=161, 73.52%) indicated that they would be comfortable with the closest degree of intimacy available as close relatives through marriage.

Preferences for intimacy with convicted felons showed different results. About half of all participants (N=51, 22.47%) indicated that they would exclude felons from their country while a small majority (N=18, 7.93%) would only be comfortable if the felon was a visitor in their country. Still other participants (N=37, 16.30%) indicated the closest degree of desired intimacy

they preferred with a criminal felon was sharing the same national citizenship while no participants wished to be co-workers with criminal felons. A few participants (N=18, 7.93%) found it acceptable to be neighbors with felons while 43 (18.94%) were comfortable having a close friendship. The remaining 60 participants (26.43%) indicated that they would comfortably associate with criminal felons as close relatives by marriage.

Six participants (2.71%) stated that they would exclude people living with HIV/AIDS from their country while eight (3.62%) indicated that would allow such people as visitors. Others (N=25, 11.31%) would allow persons with HIV/AIDS to be citizens in their country while only ten (4.52%) would be comfortable in a co-worker situation. Some (N=35, 15.84%) would associated with such people as neighbors while 54 (24.43%) would be close friends. A large number of participants (N=83, 37.56%) would willingly be associated to people with HIV/AIDS through marriage or close familial relationship.

Participants' feelings toward illegal immigrants were slightly different. About half (N=53, 22.18%) stated that they would exclude current illegal immigrants from their country while 54 (22.59%) would be comfortable with immigrants visiting their country. Some (N=20, 8.37%) said they would allow illegal immigrants to have citizenship in their country while 12 (5.02%) would be comfortable as coworkers, 16 (6.69%) as neighbors and 26 (10.88%) as close, personal friends. Only 58 participants (24.27%) indicated that they would be comfortably associated to an illegal immigrant through marriage or family-ties.

Finally, participants demonstrated a significantly less diverse opinion about the mentally ill. Three (1.39%) said they would exclude the mentally ill from their country while two (0.93%) would only be comfortable if such people were visiting their country. Only a few participants (N=17, 7.87%) would allow the mentally ill to have citizenship in their country while nine

(4.17%) would be comfortable having a mentally ill person as a coworker. Some participants (N=34, 15.74%) would be accepting of a mentally ill individual as a neighbor while 39 (18.06%) would accept them as a close personal friend. A significant amount of participants (N=112, 51.85%) stated that they would be comfortably associated to the mentally ill through family relationships or marriage.

Results of this assessment varied. When compared to legally questionable groups, such as criminal felons or illegal immigrants, participants indicated that they preferred higher contact relationships with the mentally ill. In contrast to other medical conditions, such as HIV/AIDS and cancer, participants noted some correlation. Cancer patients were significantly treated different. Less than 1% made any discrimination for each association until they were asked to live on the same street as a cancer patient. Overall, participants had no qualms about being associated to cancer victims through close friendship or familial ties.

Individuals living with HIV/AIDS and the mentally ill were more closely correlated. Participants were more willing to be associated via close family relationships to the mentally ill than they were to an individual with HIV/AIDS, but closely associated the two through every other discrimination variable. Participants ranked the mentally ill as the second most favorable (after cancer patients) group to which they would be comfortably associated with via close familial ties.

Overall, the Bogardus Social Distance Scale revealed that the mentally ill do not emerge as one of the most threatening social groups. When paired with other samples, the mentally ill were treated similarly to cancer patients and individuals living with HIV/AIDS. Cancer patients emerged as the least threatening group, yet the mentally ill followed closely behind. Participants indicated a significantly higher level of preferred association to the mentally ill over those with

HIV/AIDS, but also preferred association with cancer patients at a significantly higher level. The level of willing association with all three medically-themed groups was significantly higher than participants' willing level of association with criminal felons and illegal immigrants.

When coded for correlation, results indicate that several people groupings were correlated with other groupings, as measured in Table 1.A below. Essentially the Spearman Bivariate Correlation measures participants' perceptions of the mentally ill against their perceptions of the other groups listed in the Bogardus social distance scale. These correlating responses show how participants integrate their perceptual frameworks amongst each other.

**Table 1.A**  
**Spearman Bivariate Correlation**

	<b>CP</b>	<b>CF</b>	<b>HA</b>	<b>II</b>	<b>MI</b>
<b>Cancer Patients (CP) Pearson Correlation</b>	1	.083	.409**	.139*	.494**
Sig. (2- tailed)		.254	.000	.046	.000
N	219	193	206	208	207
<b>Convicted Felons (CF) Pearson Correlation</b>	.083	1	.149*	.016	.105
Sig. (2-tailed)	.254		.036	.814	.144
N	193	227	199	212	194
<b>HIV/AIDS (HA) Pearson Correlation</b>	.409**	.149*	1	.437**	.618*
Sig. (2-tailed)	.000	.036		.000	.000
N	206	199	221	214	206

<b>Illegal Immigrants (II)</b> Pearson Correlation	.139*	.016	.437**	1	.218**
Sig. (2-tailed)	.046	.814	.000		.001
N	208	212	214	239	212
<b>The Mentally Ill (MI)</b> Pearson Correlation	.494**	.105	.618**	.218**	1
Sig. (2-tailed)	.000	.144	.000	.001	
N	207	194	206	212	216

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

\* . Correlation is significant at the 0.05 level (2-tailed)

Results of Spearman Bivariate Correlation among participants' preferred level of social distance indicate interesting results. Participants' preferred distance from cancer patients yielded correlating significance ( $p \leq .05$ ) with their preferred distance with those with HIV/AIDS (0.000), illegal immigrants (0.046) and the mentally ill (0.000). Significance was not measured between preferred distance from cancer patients and criminal felons (0.254).

The correlation between participants' desired distance from criminal felons and the other social groups provided showed little to no correlation, with no significance among cancer patients (0.254), illegal immigrants (0.814) or the mentally ill (0.144). Only one social group yielded significance when correlated with criminal felons: people living with HIV/AIDS (0.036).

In correlations between people living with HIV/AIDSs and other social groups, significance emerged for every group. Participants' desirability for associating with such persons yielded correlating significance with cancer patients (0.000), criminal felons (0.036), illegal immigrants (0.000) and the mentally ill (0.000).

Additionally, the desirable level of association between illegal immigrants and the other groups yielded significance for several items. First, desirability was correlated significantly among illegal immigrants and cancer patients (0.046), people living with HIV/AIDS (0.000) and the mentally ill (0.001). No significance was evident, however, when correlating desired contact of illegal immigrants against desired contact with criminal felons (0.814).

Finally, when participants' preferred levels of contact with the mentally ill against other groups, several items of significance emerged. Correlations between the mentally ill yielded significance among cancer patients (0.000), people living with HIV/AIDS (0.000) and illegal immigrants (0.001). Significance was not found when correlating desired contact with the mentally ill against criminal felons (0.144).

To test for the variables related to this study, a one-way ANOVA analysis was conducted to note significance between response and the two variables of interest to this study; gender and religious involvement. Tables 1.B and 1.C below show the results of this ANOVA:

**Table 1.B**  
**ANOVA (Gender)**

		Sum of Squares	df	Mean Square	F	Sig.
Cancer Patients	Between Groups	.991	1	.991	1.590	.209
	Within Groups	132.712	213	.623		
	Total	133.702	214			
Convicted Felons	Between Groups	.192	1	.192	.033	.855
	Within Groups	1260.233	219	5.754		
	Total	1260.425	220			
HIV/AIDS	Between Groups	.060	1	.060	.022	.883
	Within Groups	598.179	215	2.782		
	Total	598.240	216			
Illegal Immigrants	Between Groups	4.070	1	4.070	.714	.399
	Within Groups	1322.392	232	5.700		
	Total	1326.462	233			

The Mentally Ill	Between Groups	.163	1	.163	.079	.778
	Within Groups	430.040	210	2.048		
	Total	430.203	211			

\*BG= Between Groups, WG= Within Groups, T=Total

No significance emerged when examining the relationship between gender and desired social distance. Similarly, as demonstrated in the graph below, significance did not emerge when testing the relationship between religious involvement and desired level of social distance. Significance was not found among convicted felons (0.489), people living with HIV/AIDS (0.504), illegal immigrants (0.171) or the mentally ill (0.530). Only cancer patients approached significance at 0.087, showing that those who are not religiously involved ( $N=5$ ,  $M=1.00$ ,  $SD=.000$ ) were the most comfortable being associated with cancer patients, followed by those that only attend required religious services ( $N=17$ ,  $M=1.18$ ,  $SD=.393$ ). The highest level of variance was found among those that only occasionally or sporadically attend religious services ( $N=14$ ,  $M=1.86$ ,  $SD=1.352$ ). Overall, relative to this study, religious involvement did not play a significant role in shaping participants' desire for social distance.

**Table 1.C**  
**ANOVA (Involvement)**

		Sum of Squares	df	Mean Square	F	Sig.
Cancer Patients	Between Groups	5.049	4	1.262	2.060	.087
	Within Groups	128.653	210	.613		
	Total	133.702	214			
Convicted Felons	Between Groups	19.747	4	4.937	.859	.489
	Within Groups	1240.678	216	5.744		
	Total	1260.425	220			
HIV/AIDS	Between Groups	9.281	4	2.320	.835	.504
	Within Groups	588.958	212	2.778		
	Total	598.240	216			

Illegal Immigrants	Between Groups	36.400	4	9.100	1.615	.171
	Within Groups	1290.061	229	5.633		
	Total	1326.462	233			
The Mentally Ill	Between Groups	6.508	4	1.627	.795	.530
	Within Groups	423.695	207	2.047		
	Total	430.203	211			

\*BG= Between Groups, WG=Within Groups, T=Total

Because no significance emerged in regard to the original variables established in the research question, further analysis was conducted. First, to see if there were any distinguishing factors within the pool sampled, an analysis of age was conducted to test for significance, as listed in the table below. Significance was not found when testing the relationships between age and desired social distance among cancer patients (0.813), convicted felons (0.650), or illegal immigrants (0.309). Significance did emerge, however, between age and participants' desired social distance from people living with HIV/AIDS (0.015), revealing that people aged 24 ( $N=2$ ,  $M=6.00$ ,  $SD=1.414$ ) desired the highest level of distance from people with HIV/AIDS, while people aged 21 desired the lowest ( $N=8$ ,  $M=1.75$ ,  $SD=0.886$ ). The number approached significance for the mentally ill (0.071), revealing that people aged 24, once again ( $N=2$ ,  $M=4.50$ ,  $SD=2.121$ ) desired the highest level of social distance, while people aged 21 ( $N=8$ ,  $M=1.50$ ,  $SD=0.535$ ) and age 22 ( $N=2$ ,  $M=1.50$ ,  $SD=.787$ ) desired the lowest.

**Table 1.D**  
**ANOVA (Age)**

		Sum of Squares	df	Mean Square	F	Sig.
Cancer Patients	BG	4.330	11	.394	.618	.813
	WG	129.372	203	.637		
	T	133.702	214			

Convicted Felons	BG	50.298	11	4.573	.790	.650
	WG	1210.127	209	5.790		
	T	1260.425	220			
HIV/AIDS	BG	63.326	11	5.757	2.206	<b>.015</b>
	WG	534.914	205	2.609		
	T	598.240	216			
Illegal Immigrants	BG	72.686	11	6.608	1.170	.309
	WG	1253.776	222	5.648		
	T	1326.462	233			
Mentally Ill	BG	37.187	11	3.381	1.720	<b>.071</b>
	WG	393.016	200	1.965		
	T	430.203	211			

\*BG= Between Groups, WG=Within Groups, T=Total

Thus, since these variables yielded more significance than the variables of focus for this research study, other variables were examined including race (1.E), religion (1.F), denomination (1.G), political association (1. H), disease relationship (1.I), and disease relationship categorization (I.J). In an effort to be concise, yet add to understanding of perceptual frameworks, the results of ANOVA with these variables are listed below. Items with significance and those that are approaching significance are listed in bold.

**Table 1.E**  
**ANOVA (Race)**

		<b>Sum of Squares</b>	<b>df</b>	<b>Mean Square</b>	<b>F</b>	<b>Sig.</b>
Cancer Patients	BG	.830	6	.138	.216	.972
	WG	132.740	207	.641		
	T	133.570	213			

Convicted Felons	BG	66.662	6	11.110	1.983	<b>.069</b>
	WG	1193.133	213	5.602		
	T	1259.795	219			
HIV/AIDS	BG	16.911	6	2.818	1.014	.417
	WG	581.084	209	2.780		
	T	597.995	215			
Illegal Immigrants	BG	36.217	6	6.036	1.060	.388
	WG	1286.916	226	5.694		
	T	1323.133	232			
Mentally Ill	BG	5.381	6	.897	.432	.857
	WG	423.690	204	2.077		
	T	429.071	210			

\*BG= Between Groups, WG=Within Groups, T=Total

Significance did not emerge for any items when examining the relationships between race and social distance preference. Associations between cancer patients and race yielded significance at 0.972. Other groups yielded non-significant associations, including people living with HIV/AIDS (0.417), illegal immigrants (0.388) and the mentally ill (0.857). Only one grouping—convicted felons—approached significance at 0.069, revealing that Pacific Islanders ( $N=2$ ,  $M=5.50$ ,  $SD=0.707$ ) desired the highest level of social distance while American Indians and Native Americans ( $N=2$ ,  $M=2.00$ ,  $SD=.000$ ) desired the least amount of distance.

Religious affiliation, closely related to the religious involvement variable of this study, also did not yield any significance, as measured in the table below. Additionally, no groups even approached significance when examining the relationships between religious affiliation and desired social distance. Cancer patients (0.736), convicted felons (0.863), people living with

HIV/AIDS (0.825), illegal immigrants (0.312) and the mentally ill (0.775) all proved not to be significantly associated with religious affiliation.

**Table 1.F**  
**ANOVA (Religion)**

		<b>Sum of Squares</b>	<b>df</b>	<b>Mean Square</b>	<b>F</b>	<b>Sig.</b>
Cancer Patients	BG	.802	3	.267	.424	.736
	WG	132.900	211	.630		
	T	133.702	214			
Convicted Felons	BG	4.300	3	1.433	.248	.863
	WG	1256.125	217	5.789		
	T	1260.425	220			
HIV/AIDS	BG	2.519	3	.840	.300	.825
	WG	595.721	213	2.797		
	T	598.240	216			
Illegal Immigrants	BG	20.379	3	6.793	1.196	.312
	WG	1306.083	230	5.679		
	T	1326.462	233			
Mentally Ill	BG	2.285	3	.762	.370	.775
	WG	427.918	208	2.057		
	T	430.203	211			

\*BG= Between Groups, WG=Within Groups, T=Total

Also closely related to the religious involvement aspect of this study, an ANOVA analysis revealed that denominational preference for religious involvement did not yield significance in its association to participants' desired levels for social distance. As measured in the graph below, cancer patients (0.848), convicted felons (0.495), people living with HIV/AIDS (0.519), illegal immigrants (0.675) and the mentally ill (0.472) all yielded numbers outside of the

realm of statistical significance, showing that there is not a significant relationships between denomination and perceptions of social distance.

**Table 1.G**  
**ANOVA (Denomination)**

		<b>Sum of Squares</b>	<b>df</b>	<b>Mean Square</b>	<b>F</b>	<b>Sig.</b>
Cancer Patients	BG	4.532	12	.378	.591	.848
	WG	129.171	202	.639		
	T	133.702	214			
Convicted Felons	BG	65.729	12	5.477	.954	.495
	WG	1194.697	208	5.744		
	T	1260.425	220			
HIV/AIDS	BG	30.987	12	2.582	.929	.519
	WG	567.235	204	2.781		
	T	598.240	216			
Illegal Immigrants	BG	53.615	12	4.468	.776	.675
	WG	1272.846	221	5.759		
	T	1326.462	233			
Mentally Ill	BG	23.949	12	1.996	.978	.472
	WG	406.254	199	2.041		
	T	430.203	211			

\*BG= Between Groups, WG=Within Groups, T=Total

Political affiliation and its relationship to participants' desired associations with the mentally ill was also measured via ANOVA. Significance did emerge, showing a relationship between political affiliation and contact with people living with HIV/AIDS, showing that republicans ( $N=149$ ,  $M=2.62$ ,  $SD=1.706$ ) were more willing to be associated to those with HIV/AIDS, while democrats ( $N=6$ ,  $M=3.17$ ,  $SD=2.137$ ) desired the highest level of social

distance. Significance did not emerge among cancer patients (0.224), convicted felons (0.494), illegal immigrants (0.207) or the mentally ill (0.342). Thus, political party affiliation is not significantly related to participants' desired levels of social distance.

**Table 1.H**  
**ANOVA (Political Affiliation)**

		<b>Sum of Squares</b>	<b>df</b>	<b>Mean Square</b>	<b>F</b>	<b>Sig.</b>
Cancer Patients	BG	2.737	3	.912	1.470	.224
	WG	130.965	211	.621		
	T	133.702	214			
Convicted Felons	BG	13.820	3	4.607	.802	.494
	WG	1246.606	217	5.745		
	T	1260.425	220			
HIV/AIDS	BG	22.529	3	7.510	2.778	<b>.042</b>
	WG	575.711	213	2.703		
	T	598.240	216			
Illegal Immigrants	BG	25.996	3	8.665	1.533	.207
	WG	1300.465	230	5.654		
	T	1326.462	233			
Mentally Ill	BG	6.833	3	2.278	1.119	.342
	WG	423.370	208	2.035		
	T	430.203	211			

\*BG= Between Groups, WG=Within Groups, T=Total

Two more tests were run to see if significance emerged between participants' association with the mentally ill, and the categorization of those relationships. The association would seem

to only yield significance for participants' level of comfortable association with the mentally ill because it relies on their association with and relationship to such a population. Interestingly enough, no significance emerged for the mentally ill on either test.

When measuring previous association with the mentally ill, cancer patients (0.674), people living with HIV/AIDS (0.628), illegal immigrants (0.912) and the mentally ill (0.645) did not yield significance. One group, interestingly enough, did yield numbers approaching significance. Convicted felons yielded significance at 0.064, showing that those who have a relationship to a mentally ill person ( $N=98$ ,  $M=2.45$ ,  $SD=1.688$ ) are more likely to associate with a criminal felon than those who do not have a relationship to the mentally ill ( $N=114$ ,  $M=2.56$ ,  $SD=1.672$ ).

**Table 1.I**  
**ANOVA (Association)**

		<b>Sum of Squares</b>	<b>df</b>	<b>Mean Square</b>	<b>F</b>	<b>Sig.</b>
Cancer Patients	BG	.113	1	.113	.178	.674
	WG	132.653	208	.638		
	T	132.767	209			
Convicted Felons	BG	19.599	1	19.599	3.477	<b>.064</b>
	WG	1211.940	215	5.637		
	T	1231.539	216			
HIV/AIDS	BG	.666	1	.666	.236	.628
	WG	592.315	210	2.821		
	T	592.981	211			
Illegal Immigrants	BG	.071	1	.071	.012	.912
	WG	1300.087	227	5.727		
	T	1300.157	228			

Mentally Ill	BG	.434	1	.434	.212	.645
	WG	419.083	205	2.044		
	T	419.517	206			

\*BG= Between Groups, WG=Within Groups, T=Total

Results for relationship categorization with the mentally ill (degree of association that participants had with the mentally ill) show similar results. Cancer patients (0.221) criminal felons (0.280), people living with HIV/AIDS (0.811), illegal immigrants (0.246) and the mentally ill (0.917) did not yield significance. This shows that individual's relationship to the mentally ill is not directly impacted by their relationship to the mentally ill.

**Table 1.J**  
**ANOVA (Categorization)**

		Sum of Squares	df	Mean Square	F	Sig.
Cancer Patients	Between Groups	4.210	5	.842	1.423	.221
	Within Groups	70.996	120	.592		
	Total	75.206	125			
Convicted Felons	Between Groups	35.228	5	7.046	1.271	.280
	Within Groups	725.954	131	5.542		
	Total	761.182	136			
HIV/AIDS	Between Groups	6.286	5	1.257	.452	.811
	Within Groups	339.432	122	2.782		
	Total	345.719	127			
Illegal Immigrants	Between Groups	37.493	5	7.499	1.354	.246
	Within Groups	753.296	136	5.539		
	Total	790.789	141			
The Mentally Ill	Between Groups	2.690	5	.538	.291	.917
	Within Groups	220.238	119	1.851		
	Total	222.928	124			

\*BG= Between Groups, WG=Within Groups, T=Total

Results from these ANOVA assessments reveal that gender and religious involvement do not play a significant role in perceptions of preferred level of social distance between individuals and the mentally ill. The social distance scales, however, are not merely sufficient enough to understand the scope of participants' perceptions of the mental health community and, more specifically, the mentally ill. The following assessment of participants' attitudes toward the mentally ill provides a more in-depth perspective, by gauging their perceptions of the mentally ill by themes of authoritarianism, benevolence, social restrictiveness and community mental health ideology.

#### *Community Attitudes Toward the Mentally Ill (CAMI)*

As discussed, Taylor and Dear's CAMI scale consists of a 40 statement likert assessment. Participants of the study were asked to indicate their level of agreement with each statement listed with options of strongly disagree, disagree, no answer, agree or strongly agree. In an effort to list results in a legible and effective way, all results of this likert CAMI assessment are detailed by their labeling factors (authoritarianism, benevolence, social restrictiveness and community mental health ideology). Not all participants completed an assessment of each statement, thus the percentages in relation to total study participants may vary for each item.

#### *Authoritarianism*

In the first ten statements, which deal with authoritarian attitudes or indicate from an authoritative standpoint the opinions of participants, participants showed significant ranges. In the first statement, which asserts that "one of the main causes of mental illness is a lack of self-discipline and will power," participants leaned more toward disagreement, with 100 participants strongly disagreeing (39.7%) and 103 (40.9%) disagreeing. Very few participants agreed with the statement, with 21 (8.3%) agreeing and 6 (2.4%) strongly agreeing. Additionally, a small

portion ( $N=26$ , 10.3%) were divided and did not select an answer. Participants also largely disagreed that “the best way to handle the mentally ill is to keep them behind locked doors.” A large number ( $N=168$ , 66.9%) strongly disagreed while 69 (27.5%) disagreed. Again, few held any level of agreement with 4 (1.6%) agreeing and 1 (0.4%) strongly agreeing. Only 10 (4.0%) did not agree nor disagree with the statement.

Results became a little more diverse in responses to the third statement when participants were confronted with the idea that “there is something about the mentally ill that makes it easy to tell them from normal people.” Only 20 (8.0%) and 70 (27.9%) disagreed and strongly disagreed, respectively. Some participants ( $N=55$ , 21.9%) were divided on the issue while 106 (42.2%) agreed and 7 (2.8%) strongly agreed. They were divided once again, however, when the statement indicated that individuals should be hospitalized as soon as they show signs of mental disturbance. Relatively few participants ( $N=59$ , 23.5%) strongly disagreed and 127 (50.6%) disagreed. Only a few participants ( $N=29$ , 11.6%) agreed and 1 (0.4%) strongly agreed, while 38 (15.1%) did not agree or disagree.

When asked if mental patients do, in fact, need the same type of control and discipline as young children, 15 (6.0%) strongly disagreed and 63 (25.0%) disagreed. 74 (29.4%) did not disagree nor agree on any level, while 87 (34.5%) agreed and 15 (6.0%) strongly agreed. Participants were split when confronted with the statement that “mental illness is an illness like any other. 21 (8.3%) strongly disagreed while 83 (32.9%) disagreed. Some 93 participants (36.9%) agreed while 18 (7.1%) strongly agreed. About 40 individuals (15.9%) did not agree nor disagree.

Participants largely agreed that “the mentally ill should not be treated as outcasts of society.” About half of the participants ( $N=122$ , 48.6%) strongly agreed and 87 (34.7%) agreed.

A small number disagreed ( $N=6$ , 2.4%) or strongly disagreed ( $N=26$ , 10.4%). Only 16 participants (6.4%) did not lean one way or the other. Additionally, a large portion of participants were not willing to commit on a statement that posed “less emphasis should be placed on protecting the public from the mentally ill.” A total of 103 (40.9%) did not agree nor disagree, while 91 (36.1%) agreed and 15 (6.0%) strongly agreed. Still, 35 participants (13.9%) disagreed and 17 (6.7%) strongly disagreed.

When asked if “mental hospitals are an outdated means of treating the mentally ill,” participants were largely unwilling to commit, with 96 (38.7%) selecting N/A as their preference. 87 (35.1%) disagreed and 16 (6.5%) strongly disagreed with the statement while 47 (19.0%) agreed and 6 (2.4%) strongly agreed that such treatment centers were outdated. In the final item of the authoritarian subset of the CAMI, participants largely indicated that “virtually anyone can become mentally ill.” 117 (47.0%) agreed while 37 (14.9%) strongly agreed. Only 38 participants disagreed (15.3%) while 7 (2.8%) strongly disagreed. The remaining 54 (21.7%) were not willing to commit.

**Table 1.K**  
**Community Attitudes toward the Mentally Ill (Authoritarianism)**

	Strongly Disagree	Disagree	N/A	Agree	Strongly Agree
1. One of the main causes of mental illness is a lack of self-discipline and will power	39.7% (100)	40.9% (103)	10.3% (26)	8.3% (21)	2.4% (6)
2. The best way to handle the mentally ill is to keep them behind locked doors	66.9% (168)	27.5% (69)	4.0% (10)	1.6% (4)	0.4% (1)
3. There is something about the mentally ill that makes it easy to tell them from normal people	8.0% (20)	27.9% (70)	21.9% (55)	42.2% (106)	2.8% (7)

4. As soon as a person shows signs of mental disturbance, they should be hospitalized	23.5% (59)	50.6% (127)	15.1% (38)	11.6% (29)	0.4% (1)
5. Mental patients need the same kind of control and discipline as a young child	6.0% (15)	25.0% (63)	29.4% (74)	34.5% (87)	6.0% (15)
6. Mental illness is an illness like any other	8.3% (21)	32.9% (83)	15.9% (40)	36.9% (93)	7.1% (18)
7. The mentally ill should not be treated as outcasts of society	10.4% (26)	2.4% (6)	6.4% (16)	34.7% (87)	48.6% (122)
8. Less emphasis should be placed on protecting the public from the mentally ill	6.7% (17)	13.9% (35)	40.9% (103)	36.1% (91)	6.0% (15)
9. Mental hospitals are an outdated means of treating the mentally ill	6.5% (16)	35.1% (87)	38.7% (96)	19.0% (47)	2.4% (6)
10. Virtually anyone can become mentally ill	2.8% (7)	15.3% (38)	21.7% (54)	47.0% (117)	14.9% (37)

### *Authoritarian Variables*

When examining statements from the authoritarian quadrant against the variables of this study for significance, interesting results emerge. First, an ANOVA testing for significance between gender and authoritarianism from the CAMI assessment yielded little to no significance. Only two statements emerged, one with statistical significance and one approaching significance. First, in statement five—“mental patients need the same kind of control and discipline as a young child”—statistical significance emerged at 0.050, showing that gender was a significant variable in participants’ thoughts on the treatment of the mentally ill. The mean of female responses out of the five options listed (1-strongly disagree, 2-disagree, 3-N/A, 4- agree and 5- strongly agree)

showed that females were more likely to disagree that the mentally ill needed childlike supervision ( $N=134$ ,  $M= 2.87$ ,  $SD=0.999$ ) than males ( $N=104$ ,  $M=3.12$ ,  $SD=0.862$ ).

Second, statement ten, which states that “virtually anyone can become mentally ill,” approached significance for gender at 0.074. Females ( $N=138$ ,  $M=3.62$ ,  $SD=0.914$ ) demonstrated a slightly higher level of agreement that anyone is susceptible to mental illness than males ( $N=111$ ,  $M=3.40$ ,  $SD=1.081$ ). Additionally, when coded for significance related to involvement, an ANOVA revealed that only one statement—“as soon as a person shows signs of mental disturbance, they should be hospitalized” (statement four)—approached significance at 0.078, showing that religious involvement was only slightly related to such perceptions. In this statements, those that were not religious involved ( $N=6$ ,  $M=3.00$ ,  $SD=1.59$ ) agreed more, while those that attended only required religious services ( $N=17$ ,  $M=1.88$ ,  $SD=0.928$ ) disagreed the most.

ANOVA analyses for the additional, secondary variables of this study did also not yield much significance for authoritarianism. ANOVA based on race only produced one statement—“the mentally ill should not be treated as outcasts of society” (statement seven)—approached significance at 0.069. In this statements, Hispanic and Latino participants ( $N=12$ ,  $M=4.42$ ,  $SD=.669$ ) demonstrated the highest level of agreement, while Pacific Islanders ( $N=2$ ,  $M=1.50$ ,  $SD=0.707$ ) disagreed the most with the statement. Religious affiliation proved to be insignificant, as was denominational affiliation.

Two statements approached significance when coded for political affiliation influence. Statement six which states “mental illness is an illness like any other,” approached significance at 0.097, revealing that Democrats ( $N=6$ ,  $M=2.00$ ,  $SD=0.632$ ) were most likely to distinguish mental illness from other diseases while those from a third party ( $N=10$ ,  $M=2.90$ ,  $SD=0.876$ )

were more likely to believe there was no difference. Additionally, in statement eight, which stated that “less emphasis should be placed on protecting the public from the mentally ill,” results approached significance at 0.060, showing that once again, Democrats ( $N=8$ ,  $M=2.63$ ,  $SD=1.188$ ) were more likely to desire higher levels of protection while those from a third party ( $N=10$ ,  $M=3.80$ ,  $SD=0.632$ ) did not feel it was necessary for more emphasis on protection.

Statement eight on this lesser degree of emphasis from protection did yield significance when tested for an association between those with a relationship to a mentally ill person at 0.041. Results of an independent sample t-test reveal that those with a relationship to a mentally ill individual were more likely to believe that less emphasis should be placed on protection ( $N=117$ ,  $M=3.31$ ,  $SD=0.895$ ) than those with no relationship to such a population ( $N=128$ ,  $M=3.05$ ,  $SD=1.022$ ).

Additionally, when coded for significance between perceptions of authoritarianism and the degree of relationships with the mentally ill, significance emerged for several statements. First, statement one, which states that “one of the main causes of mental illness is a lack of self-discipline and will power,” approached significance at 0.071. Those with an immediate family with a mental disease ( $N=30$ ,  $M=1.57$ ,  $SD=0.626$ ) were more likely to disagree, while those with a distant social relationship to a mentally ill person were most likely to agree ( $N=4$ ,  $M=2.50$ ,  $SD=1.000$ ).

Additionally, in statement four—“as soon as a person shows signs of mental disturbance, they should be hospitalized”—significance emerged at 0.003. In this category, those with a distant social relationship ( $N=4$ ,  $M=3.50$ ,  $SD=1.000$ ) were most likely to agree, yet again, while those with a mentally ill person in their extended family lineage were least likely to agree ( $N=32$ ,  $M=1.84$ ,  $SD=0.767$ ).

Responses to statement eight, which discusses a lesser degree of emphasis on protection from the mentally ill yielded significance at 0.002. In this statements, those with a distant social relationship were most likely to disagree that there should be a lesser degree of emphasis ( $N=4$ ,  $M=1.75$ ,  $SD=0.957$ ), while those who categorize their relationship to the mentally ill as an acquaintance were most likely to agree ( $N=28$ ,  $M=3.54$ ,  $SD=0.744$ ). Finally, statement nine, which states, “mental hospitals are an outdated means of treating the mentally ill,” yielded significance at 0.015, showing that those with a distant social relationship ( $N=4$ ,  $M=4.25$ ,  $SD=0.500$ ) were most likely to agree, while those with a distant family member with a mental disease were the least likely to agree ( $N=31$ ,  $M=2.65$ ,  $SD=0.839$ ).

### *Benevolence*

Statements 11-20 presented statements that dealt with benevolent and compassionate statements toward the mentally ill. Results indicated a wide variety of benevolent attitudes among participants. First, when presented with a statement that states “the mentally ill have for too long been the subject of ridicule,” participants largely agreed ( $N=120$ , 48.2%) or strongly agreed ( $N=60$ , 24.1%). 11 (4.4%) disagreed and 7 (2.8%) strongly disagreed, while 56 participants (22.5%) did not commit. When asked if “more tax money should be spent on the care and treatment of the mentally ill,” a large amount of participants ( $N=112$ , 44.8%) were not willing to commit to agree or disagree. Other results were almost equally split, with 63 (25.2%) and 6 (2.4%) agreeing or strongly agreeing, respectively and 56 (23.2%) and 17 (6.8%) disagreeing or strongly disagreeing, respectively.

In statement 13, participants indicated largely that “we need to adopt a far more tolerant attitude toward the mentally ill in our society.” Over half of all participants ( $N=143$ , 56.7%) agreed while 54 (21.4%) strongly agreed. Only 12 participants (4.8%) disagreed and 8 (3.2%)

strongly disagreed, while 37 (14.7%) did not commit. Additionally, when asked if “mental hospitals seem more like prisons than like places the mentally ill can be cared for,” participants were largely split on levels of agreement. Many participants (N=99, 39.6%) agreed with the statement while 26 (10.4%) strongly agreed. Only 26 (10.4%) disagreed while 10 (4.0%) strongly disagreed. A significant amount of participants (N=96, 39.2%) did not commit.

Participants largely agreed that “we have a responsibility to provide the best possible care for the mentally ill.” A large number (N=134, 53.2%) agreed and 67 (26.6%) strongly agreed. Only 8 disagreed (3.2%) while 9 strongly disagreed (3.6%). Still, 37 (14.7%) did not indicate agreement or disagreement. Most participants disagreed that “the mentally ill don’t deserve our sympathy,” with 130 (51.8%) strongly disagreeing and 96 (39.0%) disagreeing. Only 16 did not commit (6.4%) while 9 agreed (3.6%) and 3 strongly agreed (1.2%). Participants also largely disagreed with the statement that “the mentally ill are a burden on society.” A large number of participants—112 (44.6%) and 98 (39.0%)—disagreed and strongly disagreed, respectively. Only 9 (3.6%) agreed and 4 (1.6%) strongly agreed, while 31 (12.4%) did not commit to agree or to disagree.

Participants indicated a wide variety of agreement on the statement that “increased spending on mental health services is a waste of tax dollars.” Many (N=76, 30.4%) did not indicate any type of agreement, while 100 disagreed (40.0%) and 50 (20.0%) strongly disagreed. Only 22 participants (8.8%) agreed that such spending was wasteful while 4 (1.6%) strongly agreed. Participants largely did not commit any level of agreement on whether or not “there are sufficient existing services for the mentally ill,” with 121 (48.2%) selecting the “N/A” option. Still, 59 (23.5%) disagreed that there are enough sufficient services while 13 (5.2%) strongly

disagreed. Further, 56 (22.3%) thought that there *were* sufficient services as did 3 other participants (1.2%) which strongly agreed.

The last statement in the benevolence quadrant, which stated that “it is best to avoid anyone who has mental problems,” saw a large amount of disagreement. A few participants (N=97, 38.5%) strongly disagreed while 126 (50.0%) disagreed. Only 8 participants (3.2%) agreed while the remaining 22 (8.7%) did not commit.

**Table 1.L**  
**Community Attitudes toward the Mentally Ill (Benevolence)**

	Strongly Disagree	Disagree	N/A	Agree	Strongly Agree
11. The mentally ill have for too long been the subject of ridicule	2.8% (7)	4.4% (11)	22.5% (56)	48.2% (120)	24.1% (60)
12. More tax money should be spent on the care and treatment of the mentally ill	6.8% (17)	23.2% (56)	44.8% (112)	25.2% (63)	2.4% (6)
13. We need to adopt a far more tolerant attitude toward the mentally ill in our society	3.2% (8)	4.8% (12)	14.7% (37)	56.7% (143)	21.4% (54)
14. Our mental hospitals seem more like prisons than like places the mentally ill can be cared for	4.0% (10)	10.4% (26)	39.2% (96)	39.6% (99)	10.4% (26)
15. We have a responsibility to provide the best possible care for the mentally ill	3.6% (9)	3.2% (8)	14.7% (37)	53.2% (134)	26.6% (67)
16. The mentally ill don't deserve our sympathy	51.8% (130)	39.0% (96)	6.4% (16)	3.6% (9)	1.2% (3)
17. The mentally ill are a burden on society	39.0% (98)	44.6% (112)	12.4% (31)	3.6% (9)	1.6% (4)
18. Increased spending on mental health services is a waste of tax dollars	20.0% (50)	40.0% (100)	30.4% (76)	8.8% (22)	1.6% (4)

19. There are sufficient existing services for the mentally ill	5.2% (13)	23.5% (59)	48.2% (121)	22.3% (56)	1.2% (3)
20. It is best to avoid anyone who has mental problems	38.5% (97)	50.0% (126)	8.7% (22)	3.2% (8)	0.0% (0)

### *Benevolent Variables*

The researcher conducted a similar ANOVA assessment to test for significance between benevolent factors and the variables related to this study. Gender and religious involvement were given attention first, and then additional secondary variables were analyzed in an effort to provide the most in-depth information. For benevolent statements, gender did not emerge as a statistically significant variable for any statement. Only statement 17—“the mentally ill are a burden on society”—approached significance at 0.093. In this statement, females had a slightly higher level of disagreement ( $N=137$ ,  $M=1.76$ ,  $SD=0.862$ ) than males ( $N=114$ ,  $M=1.95$ ,  $SD=.901$ ). No statements in the benevolence category yielded significance for religious involvement. Thus, it can be deduced that gender and religious involvement are not significant contributors to perceptions of benevolence toward the mentally ill.

Statement 14, which states, “our mental hospitals seem more like prisons than like places the mentally ill can be cared for,” approached significance at 0.061 when tested for the influence of race. In this statement, American Indians/Native Americans ( $N=2$ ,  $M=4.00$ ,  $SD=1.414$ ) were most likely to agree while Pacific Islanders ( $N=2$ ,  $M=2.50$ ,  $SD=0.707$ ) were least likely to agree. Religious affiliation did not produce significance in the benevolence assessment, nor did denominational affiliation.

Political affiliation did yield significance when coded against benevolent statements. First, statement 13—“we need to adopt a far more tolerant attitude toward the mentally ill in our

society”—produced significance for political affiliation at 0.045, showing that those belonging to a third-party agreed the most for more tolerance ( $N=10$ ,  $M=4.40$ ,  $SD=0.516$ ) while Democrats disagreed the most ( $N=8$ ,  $M=3.75$ ,  $SD=1.389$ ). Additionally, responses to statement 14, which dealt with the comparison of mental hospitals to prisons, produced significance at 0.007, showed that Republicans agreed the most that such institutions were prison-like ( $N=172$ ,  $M=3.30$ ,  $SD=0.885$ ), while Democrats disagreed the most ( $N=8$ ,  $M=3.00$ ,  $SD=1.069$ ).

Those with a relationship to a mentally ill individual approached statistical significance (0.092) in response to statement 13 about tolerance, showing that those with a relationship to a mentally ill person ( $N=118$ ,  $M=3.97$ ,  $SD=0.826$ ) were more likely to argue for more tolerance over those with no relationship ( $N=128$ ,  $M=3.77$ ,  $SD=0.949$ ). Significance emerged for statement 19 which states that “there are sufficient existing services for the mentally ill” at 0.027, revealing that those with a relationship to the mentally ill ( $N=117$ ,  $M=2.79$ ,  $SD=0.797$ ) were more likely to disagree while those with no relationship ( $N=128$ ,  $M=3.02$ ,  $SD=0.865$ ) were more likely to believe there were enough existing services. The degree of relationship to that mentally ill person, however, did not prove to be a significant variable, with no statements yielding significance when tested against the relationship categorization.

### *Social Restrictiveness*

In statements 21-30, participants assessed statements that dealt with themes of restriction for mentally ill individuals. In statement 21, which indicated that “the mentally ill should not be given any responsibility,” 3 (1.2%) participants indicated they strongly agreed while 13 (5.2%) agreed. Most disagreed, with 119 (47.4%) disagreeing and 68 (27.1%) strongly disagreeing. Still, 50 participants (19.9%) did not commit. For the statement, “the mentally ill should not be isolated from the rest of society,” participants largely disagreed with 119 (47.6%) strongly

disagreeing and 107 (42.8%) disagreeing. Only 21 did not commit (8.4%) while 5 agreed (2.0%) and 1 strongly agreed (0.4%).

Most participants disagreed that “a woman would be foolish to marry a man who has suffered from mental illness, even if he seems fully recovered,” with 72 strongly disagreeing (28.7% and 117 (46.6%) disagreeing. Some 53 did not commit (21.2%) while 10 agreed (4.0%) and 2 strongly agreed (0.8%). Additionally, most participants disagreed that they would not want to live next door to someone who has been mentally ill, with 70 strongly disagreeing (28.0%) and 100 (40.0%) disagreeing. Only 21 agreed they would not want to live next to such a person (8.4%) while 4 strongly agreed (1.6%), and 56 participants did not indicate a preference (22.4%).

Participants had mixed opinions about those with a history of mental illness taking public office, with 29 strongly disagreeing they should be excluded (11.6%), 71 disagreeing (28.3%), and 78 opting to not provide an opinion (31.1%). Only 60 participants agreed that those with previous mental issues should be excluded from public office (23.9%) while 15 strongly agreed (6.0%). Most participants agreed that “the mentally ill should not be denied their individual rights,” with 106 agreeing (42.6%) and 78 strongly agreeing (31.3%). Still, 35 did not commit (14.1%) while 13 disagreed (5.2%) and 21 strongly disagreed (8.4%). Additionally, most agreed that “mental patients should be encouraged to assume the responsibilities of normal life, with 138 agreeing (54.8%) and 41 strongly agreeing (16.3%). Only 7 strongly disagreed (2.8%) while 23 (9.1%) disagreed and 46 (18.3%) did not provide their opinion.

Keeping with this positive view of the mentally ill, 119 participants (47.4%) indicated that “no one has the right to exclude the mentally ill from their neighborhood, while 72 participants (28.7%) strongly agreed. 13 (5.2%) disagreed and 8 (3.2%) strongly disagreed with this statement, leaving 39 participants (15.5%) with no firm opinion on the issue. Participants

also largely believed that “the mentally ill are far less of a danger than most people suppose,” with 100 participants (39.7%) agreeing and 24 participants (9.5%) strongly agreeing. A mere 21 disagreed (8.3%) while 9 strongly disagreed (3.6%). However, 98 (38.9%) participants did not indicate their position on this statement. Participants were also largely uncommitted to the opinion statement that “most women who were once patients in a mental hospital can be trusted as babysitters.” A large number of participants (N=100, 40.0%) selected “N/A”. Around 98 (39.2%) disagreed while 34 (13.6%) strongly disagreed. A mere 19 participants (7.6%) agreed, while only 3 (1.2%) strongly agreed.

**Table 1.M**  
**Community Attitudes toward the Mentally Ill (Social Restrictiveness)**

	Strongly Disagree	Disagree	N/A	Agree	Strongly Agree
21. The mentally ill should not be given any responsibility	27.1% (68)	47.4% (119)	19.9% (50)	5.2% (13)	1.2% (3)
22. The mentally ill should not be isolated from the rest of the community	47.6% (119)	42.8% (107)	8.4% (21)	2.0% (5)	0.4% (1)
23. A woman would be foolish to marry a man who has suffered from mental illness, even if he seems fully recovered	28.7% (72)	46.6% (117)	21.1% (53)	4.0% (10)	0.8% (2)
24. I would not want to live next door to someone who has been mentally ill	28.0% (70)	40.0% (100)	22.4% (56)	8.4% (21)	1.6% (4)
25. Anyone with a history of mental problems should be excluded from taking public office	11.6% (29)	28.3% (71)	31.1% (78)	23.9% (60)	6.0% (15)

26. The mentally ill should not be denied their individual rights	8.4% (21)	5.2% (13)	14.1% (35)	42.6% (106)	31.3% (78)
27. Mental patients should be encouraged to assume the responsibilities of normal life	2.8% (7)	9.1% (23)	18.3% (46)	54.8% (138)	16.3% (41)
28. No one has the right to exclude the mentally ill from their neighborhood	3.2% (8)	5.2% (13)	15.5% (39)	47.4% (119)	28.7% (72)
29. The mentally ill are far less of a danger than most people suppose	3.6% (9)	8.3% (21)	38.9% (98)	39.7% (100)	9.5% (24)
30. Most women who were once patients in a mental hospital can be trusted as babysitters	13.6% (34)	39.2% (98)	40.0% (100)	7.6% (19)	1.2% (3)

### *Social Restriction Variables*

When coded for variables related to social restrictiveness, gender and religious involvement did not yield significant results. Statement 26, which says that “the mentally ill should not be denied their individual rights,” approached significance when tested for gender at 0.076 with males ( $N=111$ ,  $M=3.98$ ,  $SD=1.079$ ) demonstrating a higher level of agreement than females ( $N=138$ ,  $M=3.72$ ,  $SD=1.226$ ). Additionally, statement 23—“a woman would be foolish to marry a man who has suffered from mental illness, even if he seems fully recovered”—approached significance when tested for the influence of religious involvement at 0.083, with those who willingly attend two or more services per week ( $N=137$ ,  $M=1.93$ ,  $SD=0.815$ ) most likely to disagree while those that occasionally attend services ( $N=17$ ,  $M=2.53$ ,  $SD=0.748$ ) were most likely to agree. Much like the other quadrants studied, gender and religious involvement did not play a significant role in participants’ social restriction perceptions.

Statement 29, which states that “the mentally ill are far less of a danger than most people suppose,” approached significance when tested against influence of race at 0.073, with results showing that those that did not indicate a race ( $N=14$ ,  $M=3.79$ ,  $SD=0.975$ ) were most likely to agree while Hispanics and Latinos were least likely to agree ( $N=12$ ,  $M=-2.75$ ,  $SD=0.965$ ). Religious and denominational affiliations did not yield significance in any of the social restrictiveness statements.

Political affiliation did produce significance on two statements. First, statement 25, which says that “anyone with a history of mental problems should be excluded from taking public office,” produced significance at 0.003, showing that third-party participants were more open to a mentally ill person accepting a political role ( $N=10$ ,  $M=2.70$ ,  $SD=1.160$ ) while Republicans were most likely to exclude the mentally ill from such positions ( $N=173$ ,  $M=2.99$ ,  $SD=1.092$ ). Additionally, statement 29, which proposes that “the mentally ill are far less of a danger than most people suppose,” also produced significance at 0.003 and showed that third-party participants were most likely to agree ( $N=10$ ,  $M=4.10$ ,  $SD=0.316$ ) while Democrats were least likely to agree ( $N=8$ ,  $M=2.75$ ,  $SD=1.165$ ).

Statement 27, which states that “mental patients should be encouraged to assume the responsibilities of normal life,” approached significance when tested against participants with a relationship to the mentally ill at 0.052, revealing that those with a relationship to the mentally ill ( $N=118$ ,  $M=3.81$ ,  $SD=0.933$ ) were more likely to agree that the mentally ill should assume basic responsibilities while those with not relationship were more likely to disagree ( $N=128$ ,  $M=3.58$ ,  $SD=0.952$ ). No statistical significance was found between participants’ declared relationship with the mentally ill and statements dealing with social restrictions.

*Community Mental Health Ideology*

In the final 10-question quadrant, participants were presented with statements that dealt with the location of mental health facilities. In statement 31 one, which states that “residents should accept the location of mental health facilities in their neighborhood to serve the needs of the local community,” 120 participants agreed (47.6%) while 6 strongly agreed (2.4%). Only 98 participants provided no opinion (38.9%) while 22 disagreed (8.7%) and 9 strongly disagreed (3.6%). Most agreed that “the best therapy for many mental patients is to be part of a normal community.” In this statement, 129 participants agreed (51.4%) while 27 strongly agreed (10.8%). Only 18 disagreed (7.2%) while 4 (1.6%) strongly disagreed. Still, 79 indicated no preference (31.5%).

Most participants also agreed that “as far as possible, mental health services should be provided through community-based facilities.” Here, 111 agreed (44.2%) while 15 (6.0%) strongly agreed, 25 disagreed (10.0%) and 9 strongly disagreed (3.6%). Only 98 participants (39.0%) did not commit. Participants were largely unwilling to commit to the statement that read, “locating mental health services in residential neighborhoods does not endanger local residents.” Here, 116 participants (46.2%) did not provide an answer while 67 (26.7%) agreed, 8 (2.8%) strongly agreed, 55 disagreed (21.9%) and 9 (3.6%) strongly disagreed.

The results opened up a little more with the statement that “residents have nothing to fear from people coming into their neighborhood to obtain mental health services.” Only 6 strongly disagreed (2.4%) while 66 disagreed (26.2%). A total of 98 were uncommitted (38.9%) while 77 agreed (30.6%) and 8 strongly agreed (3.2%). Similarly, 81 participants (32.1%) disagreed that “mental health facilities should be kept out of residential neighborhoods,” while 12 (4.8%) strongly disagreed. Only 57 agreed with this statement (22.6%) and 8 strongly agreed (3.2%), leaving 95 participants (37.7%) uncommitted.

In response to the statement, “local residents have good reason to resist the location of mental health services in their neighborhood,” 86 participants agreed (34.1%) while 5 strongly agreed (2.0%). A total of 99 were uncommitted (39.3%) while 55 disagreed (21.8%) and 9 strongly disagreed (3.6%). Additionally, 84 participants (33.5%) disagreed and 17 participants (6.8%) strongly disagreed that “having mental patients living within residential neighborhoods might be good therapy but the risks to residents are too great.” Here, 46 agreed (18.3%) and 11 strongly agreed (4.4%), leaving 94 participants (37.5%) uncommitted.

Most disagreed that “it is frightening to think of people with mental problems living in residential neighborhoods,” with 106 participants (42.1%) disagreeing and 28 strongly disagreeing (11.1%). Some were uncommitted (N=79, 31.3%) while 39 agreed (15.5%) and 2 strongly agreed (0.8%). Finally, in statement 40, 82 participants (32.5%) disagreed that “locating mental health facilities in a residential area downgrades the neighborhood,” while 22 (8.7%) strongly disagreed, 63 agreed (25.0%) and 10 strongly agreed (4.0%). A total of 81 participants (32.1%) did not indicate their opinion for this statement.

**Table 1.N**  
**Community Attitudes toward the Mentally Ill (Community Ideology)**

	Strongly Disagree	Disagree	N/A	Agree	Strongly Agree
31. Residents should accept the location of mental health facilities in their neighborhood to serve the needs of the local community	3.6% (9)	8.7% (22)	38.9% (98)	47.6% (120)	2.4% (6)
32. The best therapy for many mental patients is to be part of a normal community	1.6% (4)	7.2% (18)	31.5% (79)	51.4% (129)	10.8% (27)

33. As far as possible, mental health services should be provided through community-based facilities	1.6% (4)	10.0% (25)	39.0% (98)	44.2% (111)	6.0% (15)
34. Locating mental health services in residential neighborhoods does not endanger local residents	3.6% (9)	21.9% (55)	46.2% (116)	26.7% (67)	2.8% (7)
35. Residents have nothing to fear from people coming into their neighborhood to obtain mental health services	2.4% (6)	26.2% (66)	38.9% (98)	30.6% (77)	3.2% (8)
36. Mental health facilities should be kept out of residential neighborhoods	4.8% (12)	32.1% (81)	37.7% (95)	22.6% (57)	3.2% (8)
37. Local residents have good reason to resist the location of mental health services in their neighborhood	3.6% (9)	21.8% (55)	39.3% (99)	34.1% (86)	2.0% (5)
38. Having mental patients living within residential neighborhoods might be good therapy but the risks to residents are too great	6.8% (17)	33.5% (84)	37.5% (94)	18.3% (46)	4.4% (11)
39. It is frightening to think of people with mental problems living in residential neighborhoods	11.1% (28)	42.1% (106)	31.3% (79)	15.5% (39)	0.8% (2)
40. Locating mental health facilities in a residential area downgrades the neighborhood	8.7% (22)	32.5% (82)	32.1% (81)	25.0% (63)	4.0% (10)

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*\*Response count varies per item listed*

#### *Community Mental Health Ideology Variables*

Gender proved to be a significant variable in response to statement 36, which states that “mental health facilities should be kept out of residential neighborhoods,” yielding significance at 0.030. In this statements, females ( $N=138$ ,  $M=2.78$ ,  $SD=0.880$ ) were slightly more accepting

of community-based mental health facilities than males ( $N=114$ ,  $M=3.03$ ,  $SD=0.945$ ). No other statements yielded or approached statistical significance when testing gender against participants' perceptions of community-based mental health facilities.

Similarly, religious involvement only approached significance in statement 31—“residents should accept the location of mental health facilities in their neighborhood to serve the needs of the local community”—showing a correlation between religious involvement and community mental health ideology at 0.058. For this statement, those that willing attend one religious service per week ( $N=75$ ,  $M=3.51$ ,  $SD=0.665$ ) were the most likely to agree that residents should accept such facilities, while those that only occasionally attend religious services ( $N=17$ ,  $M=2.88$ ,  $SD=0.781$ ) were the most likely to disagree.

Race did not produce significance as a variable for the final quadrant statements, nor did religious or denominational affiliations. Political affiliation yielded significance for statement 33, which states that, “as far as possible, mental health services should be provided through community-based facilities,” at 0.038, showing that Democrats were most likely to disagree with community-based mental health facilities ( $N=8$ ,  $M=2.75$ ,  $SD=1.035$ ) while those belonging to a third party ( $N=10$ ,  $M=3.50$ ,  $SD=0.850$ ) were most likely to agree with such efforts..

Additionally, statement 34 which states that, “locating mental health services in residential neighborhoods does not endanger local residents,” yielded significance for political affiliation at 0.040, revealing that Democrats were most likely to perceive the mentally ill as a threat ( $N=8$ ,  $M=2.50$ ,  $SD=0.926$ ) while third-party participants ( $N=10$ ,  $M=3.30$ ,  $SD=0.675$ ) were least likely to see such individuals as a threat.

Having a relationship to a mentally ill person provided significance for several statements relating to locating mental health facilities in residential neighborhoods. Statement 31, dealing

with residents' acceptance of community-based mental health facilities, yielded significance at 0.003 among those with a relationship to a mentally diseased person, revealing that those with a relationship ( $N=118$ ,  $M=3.50$ ,  $SD=0.701$ ) were more likely to agree that such facilities should be accepted while those with no relationship ( $N=128$ ,  $M=3.20$ ,  $SD=0.896$ ) disagreed to a higher level.

Statement 32, asserting that “the best therapy for many mental patients is to be part of a normal community,” approached significance at 0.078, showing that those with a relationship ( $N=117$ ,  $M=3.66$ ,  $SD=0.822$ ) were more likely to agree while those with no relationship ( $N=128$ ,  $M=3.47$ ,  $SD=0.851$ ) were most likely to disagree. Additionally, statement 33 which states that mental health services should be community based yielded significance at 0.026 and revealed that those with a relationship ( $N=118$ ,  $M=3.53$ ,  $SD=0.770$ ) agreed with a community based approach while those with no relationship were more likely to disagree ( $N=127$ ,  $M=3.29$ ,  $SD=0.856$ ) were most likely to disagree. Finally, statement 34, which states that “locating mental health services in residential neighborhoods does not endanger local residents,” was significant at 0.005, showing that those with a relationship ( $N=118$ ,  $M=3.14$ ,  $SD=0.765$ ) were more likely to agree than those with no relationship ( $N=127$ ,  $M=2.84$ ,  $SD=0.886$ ).

Interestingly, categorization of disease relationship only approached significance for statement 31 about the acceptance of mental health facilities at 0.073. In this statement, those with a distant social relationship to someone with a mental disease ( $N=4$ ,  $M=4.00$ ,  $SD=0.000$ ) were most likely to agree that community based-mental health facilities should be accepted by residents while those with a distant family member who was mentally ill ( $N=32$ ,  $M=3.28$ ,  $SD=0.634$ ) were most likely to disagree that such services should be accepted.

### *Discussion*

This study sought to gain more insight into perceptions of the mentally ill. As noted in the literature review, this people group has been repeatedly examined. The results from all studies conducted vary, presenting a call for further research on the mentally ill and the social situations that surround such a people group. This research report makes an attempt to answer that call by further examining specific variables related to perceptions of the mentally ill, in this case, gender and religious involvement.

In hindsight, these two variables were appropriate for study. In similar tests of perceptual frameworks and the mentally ill, gender has been examined but has not been given significant focus (Cohen and Struening; Taylor and Dear). Society is becoming increasingly more integrative of gender roles thus making it significant to study gender in research studies to examine its possible implications. Additionally, religious involvement is an important aspect because it involves a willing association with some governing entity. It is important to test the implications that regular and scattered religious service attendance has on perceptions, as well as test how religiously uninvolved individuals frame those same perceptions.

The following assessment of research questions will discuss the results and findings from this study at a more in-depth level, noting how perceptions of the mentally ill manifested in the sample used for this study as well how variables could have potentially impacted results.

**(RQ1)** What are the latitudes of acceptance, rejection and non-commitment that college students identify in their perceptions of the mental health community?

In scope, Social Judgment Theory appears to be a strong, guiding framework. The theory focuses specifically on “stands” or viewpoints of other people, groups or social issues.

Immediately, the mentally ill fall into that structure because they are (1) people, (2) a collective group and (3) married together by a social issue. Second, the theory states explicitly that “[a]n

individual's attitude on an issue can be assessed adequately only if the procedures yield the limits of the position he accepts (latitude of acceptance) and the limits of positions he rejects (latitude of rejection), relative to the bounds of available alternatives defined by the extreme positions on the issue" (Sherif, Shierf and Nebergall, 3). This would line up quite nicely with a study on the perceptions of the mentally ill, thus it seemed to fit well within the scope of this study.

Sherif's theory also accounts for areas in which individuals are unwilling to commit as "favorably or unfavorably disposed under the circumstances," known as the latitude of noncommitment. It initially seemed that a likert assessment with an option labeled "N/A" would account for this area of noncommittment because likert assessments scale positive, negative and non-committed opinions.

Furthermore, the sole basis of Social Judgment Theory deals with attitudes. Sherif, Sherif and Nebergall define attitudes as "the stands the individual upholds and cherishes about objects, issues, persons, groups or institutions" (Sherif, Sherif and Nebergall, 4). This appeared relevant to the study in several ways. First, attitudes were the sole focus of the study. Second, this focus accounted for the fact that attitudes are directly influenced by a variety of factors, including worldviews (religious and political ideologies), social relationships (family memberships, relationship to the mentally ill) and other factors (gender, race, educational status). The theory appeared to account for all variables measured for this study.

In response to the research question, participants' latitudes of acceptance, rejection and non-commitment range significantly. Broken down by each quadrant—authoritarianism, benevolence, social restrictiveness and community mental health ideology—participants measured these latitudes in a variety of different ways. In the authoritarian quadrant, it seems

that participants had a largely positive view of the mentally ill. They largely disagreed with statements that framed the mentally ill in a bad light. A significant 78.6% of participants disagreed on some level that a lack of self-discipline and will power are the cause of mental illness, while 94.4% disagreed that the mentally ill should be restrained behind locked doors. Additionally, 74.1% of participants disagreed that individuals should be hospitalized as soon as they show any signs of mental illness while 83.3% agreed that the mentally ill should not be ostracized or treated as outcasts. Even still, 60.9% of participants believed that virtually anyone was susceptible to mental illness.

These quadrants show that participants' latitudes of acceptance. Several latitudes of non-commitment, however, were evident as well. Participants were largely divided on several statements, with many not committing (by selecting the "N/A" option), or having split percentages almost equally among agreement and disagreement options. Participants did not indicate a sweeping opinion to statements that asserted there is something different and distinguishable about the mentally ill, mental patients require child-like care, less emphasis should be placed on protecting the public from the mentally ill, that mental hospitals are an outdated treatment method or that mental illness is an illness like any other.

It seems that in issues dealing with authoritarianism, participants were largely favorable toward the mentally ill or were strategically non-committed to opinion statements. Statements that dealt with harsh treatment, such as keeping the mentally ill behind locked doors or hospitalizing anyone with minor signs of mental illness, were typically cast down. More innocent versions of these statements, however, such as treating the mentally ill with child-like patience and providing a distinction between the well and the mentally ill, caused division among participants' agreement levels. Overall, participants seemed willing to either give the benefit of

the doubt toward the mental health community or remain largely indecisive and uncommitted about how they should be treated.

In the benevolence quadrant of statements, participants demonstrated this same pro-mentally ill stance. Participants demonstrated more positive opinions in the benevolence portion while avoiding any overwhelming anti-mental health opinions. A significant 72.3% of participants agreed on some level that the mentally ill have been too often ridiculed while 78.1% agreed that there should be a more tolerant attitude toward the mental health community. About 50% of participants agreed on some level that mental health facilities are too prison-like and inappropriate, while 79.8% indicated that there is a social responsibility to care for the mentally ill.

An overwhelming 90.8% of participants believe that the mentally ill deserve sympathy while 83.6% do not feel that the mentally ill are a burden on society. Additionally, 60% of participants did not believe that increased spending of tax money on mental health facilities was a waste. Even further, 88.5% said that it is not appropriate to demonstrate avoidance toward the mentally ill. Participants did demonstrate division on some statements, namely on the statement that called for increased spending of tax money for the treatment of the mentally ill and another that stated enough services already exist to care for the mentally ill.

Overall, participants demonstrated a large amount of benevolence toward the mental health community. Attitudes showed a large acceptance of benevolent treatment of the mentally ill, with only two statements causing division among participants, with participants not willing to commit to more monetary contributions to the mental health community—which leans toward a negative view of mental health care—or to the idea that there are sufficient existing services for

the mentally ill—which leans toward a positive and affirming view. No rejector statements emerged as a majority in the benevolence quadrant.

In the social restrictiveness quadrant, participants demonstrated more obvious ranges in opinion. Many statements, like the other quadrants, held a positive-leaning view of the mentally ill. 74.5% of participants believed that the mentally ill could handle responsibility while 71.1% believed the mentally ill should be encouraged to resume the normal responsibilities of life. Around 75% also believed that it would be perfectly acceptable to marry someone with a history of mental illness, 68% indicated they would not mind living next door to someone with a mental illness and 73.9% believed that the mentally ill should have access to all of their rights as a citizen. Finally, 76.1% of participants believed that no one has the right to exclude the mentally ill from their neighborhood.

In contrast to this, however, participants demonstrated a view of mental health that was somewhat hostile, stating that the mentally ill should be isolated from the rest of the community (90.4%) and that women who were once mental health patients should not be trusted as babysitters (52.8%), demonstrating latitudes of rejection in the sample used. Two statements also yielded latitudes of non-commitment. First, participants were not willing to commit to excluding someone from taking public office if they have had a history with mental health issues. Additionally, participants demonstrated a latitude of non-commitment by remaining divided over whether the mentally ill were as much of a social danger as most people suppose.

This social restriction quadrant was the first to display any latitudes of rejection. Participants still held a largely pro-mental patient view, but it seems that statements that deal with actual location and proximity to mentally ill individuals, as opposed to mere perceptions of such people, yielded different results altogether. Thus, it seems that in response to the research

questions, statements dealing with social restriction lean toward acceptance, but not to the degree of the authoritarian and benevolence quadrants.

Finally, in the final quadrant of CAMI statements, dealing with items of community mental health ideology, participants demonstrated the highest level of non-commitment. Only two statements—“the best therapy for many mental patients is to be part of a normal community” and “it is frightening to think of people with mental problems living in residential neighborhoods”—manifested latitudes of acceptance and pro-mental illness. Over half of all participants (62.2%) thought that the mentally ill needed community involvement and 53.2% did not find it frightening to live in the same residential neighborhoods as the mentally ill.

Most statements in this quadrant, however, showed participants' latitudes of non-commitment. Aside from the two statements above, participants were typically non-committed to the remaining statements, including statements about residents accepting the location of mental health facilities in community neighborhoods, mental health services being run through community-based facilities, the danger that such facilities pose, and how such facilities might downgrade the neighborhood. Participants were not readily willing to commit to these answers, splitting their answers among the various quadrants. Thus, it appears that among statements dealing with community mental health ideology, participants largely demonstrated latitudes of non-commitment when dealing with statements about community-based mental health facilities.

As a whole, it seems that participants in this sample had large latitudes of acceptance and non-commitment and rather small latitudes of rejection. Participants were largely favorable toward the mentally ill, with only two statements in the social restriction category being rejected by the majority. The social distance scale reflects this sentiment toward the mentally ill on a smaller scale. Overall, the Bogardus social distance scale revealed that, out of the groups listed,

participants held a higher view of the mentally ill. Aside from cancer patients, participants indicated that they would prefer to associate with the mentally ill the most. The mentally ill were less stigmatized than persons living with HIV/AIDS, criminal felons and illegal immigrants. Obviously, individuals might not have not enough knowledge about the mentally ill or the mental health community and thus chose these options.

In response to the first research question, it seems that the latitudes of acceptance, rejection and non-commitment are quite comprehensive and show that there are greater latitudes of acceptance and non-commitment and little to no deep latitudes of rejection. This answer might not be appropriately understood using Social Judgment Theory, which will be discussed further in the following chapter.

This study, however, does not rely solely on these latitudes. Gender and religious involvement were the variables of focus for this study with the goal being to unveil any significant correlation between gender, religious involvement and perceptions of the mentally ill. In response to the original research questions, this study found no direct correlation between gender or religious involvement and perceptions of the mentally ill. The following assessment of **RQ2** and **RQ3** detail these findings:

**(RQ2)** Does gender influence college student perceptions of the mentally ill?

For this study, gender was found to be non-significant. Significance for this study in all statistical analyses was measured at 0.05. In the Bogardus Social Distance Scale, significance for the mentally ill assessment was listed as 0.53; far away from significance. The only quadrant that measured close to significant in social distance and gender was the cancer patient quadrant, measuring at 0.087 and still only *approaching* significance, showing that those who are not religiously involved ( $N=5$ ,  $M=1.00$ ,  $SD=.000$ ) were the most comfortable being associated with

cancer patients, followed by those that only attend required religious services ( $N=17$ ,  $M=1.18$ ,  $SD=.393$ ). The highest level of variance was found among those that only occasionally or sporadically attend religious services ( $N=14$ ,  $M=1.86$ ,  $SD=1.352$ ).

When examining the CAMI assessment for significance, no authoritarian, benevolent or community mental health ideology quadrants yielded significance for gender. Only one statement under the social restrictiveness category—“the mentally ill should not be denied their individual rights” (statement 26)—yielded significance for gender at 0.021. In this statement, males ( $N=111$ ,  $M=3.98$ ,  $SD=1.079$ ) demonstrated a higher level of agreement than females ( $N=138$ ,  $M=3.72$ ,  $SD=1.226$ ). Still, overall gender did not prove to be a significant variable.

The fact that gender did not reveal any significant results is somewhat shocking. Several studies have found a significant difference in perceptions of the mentally ill based on gender. Currin, Hayslip and Temple found that women tend to have higher level of biases against the mentally ill and greater breadth of understanding of mental illness than men in two out of three of longitudinal studies (Currin, Hayslip and Temple 336). The same study also found that “women seem to be more advantaged attitudinally over time than are men” (336-337). This work is consistent with other findings that suggest men require more education in how to appropriately deal with the mentally ill (Albizu-Garcia et al.; Ojeda and Bergstresser; Ojeda and McGuire).

An Australian study from Revley and Jorm used a similar scale to measure social distance and found significance in several items related to gender. Their study revealed that men had lower desires to be associated to the mentally ill through marriage than women as well as associated through social events (Revley and Jorm 1089-1092). A similar study by Aromaa and associates revealed similar results. Men (along with older people and those who had no direct contact with a mentally ill person) were shown to have higher levels of stigma in preferred level

of social distance (128-129). These results are validated by several other studies (Adewuya, and Makanjuola; Gordan et al.; Jackson and Heatherington; Phelan and Basow).

Angermeyer, Matschinger and Holzinger found that gender did play a role on several items of a social distance scale but not as a whole. For instance, they reported that women showed higher levels of anxiety in relation to the mentally ill and that they often demonstrated more “pro-social” reactions than man (112-114). The scholars also found that social distance was often more pronounced by men than it was from women. Regardless, the study concluded that gender was not a significant influent in determining social distance because although differences were measured, no significance emerged (113).

Gender has not typically yielded significant results in the CAMI assessments of other studies. One found study by Hinkelman and Granello found that “[i]n general, males scored in a less tolerant direction on two of the four CAMI subscales (Benevolence and Social Restrictiveness)” (Hinkelman and Granello, 267). Their results do show, however, that this assessment is based on adherence to hypergender ideology, not biological sex. “Correlations between the instruments demonstrate that persons with higher hypergender scores were more likely to be more authoritarian, more socially restrictive, and less benevolent toward persons with mental illnesses, as well as holding less tolerant beliefs about community mental health” (267).

Most studies found that gender had a small effect on participants’ perceptions in the CAMI assessment, yet deduce that it does not play a significant role. This study presents similar results. Gender does impact responses to a small degree, but not enough to yield significance. Ultimately, more research needs to be conducted to understand the true degree of influence that gender has on perceptions of the mentally ill. Similarly, more research must be conducted on the

correlation between religious involvement and perceptions of the mentally ill. The following analysis of **RQ3** discusses the role that religious involvement played in this study:

**(RQ3)** Does the level of religious involvement that college students identify correlate to their perceptions of the mentally ill?

As with gender, religious involvement also appeared to play no significant role in the formation of perceptions of the mentally ill. No items were even close to approaching significance in the social distance assessment. Several elements of the CAMI test did yield significance for religious involvement, however. Under the social restrictiveness quadrant, statement 23, which states “a woman would be foolish to marry a man who has suffered from mental illness, even if he seems fully recovered,” approached significance of 0.083, revealing that those that willingly attend two or more services per week ( $N=137$ ,  $M=1.93$ ,  $SD=0.815$ ) were most likely to disagree while those that occasionally attend services ( $N=17$ ,  $M=2.53$ ,  $SD=0.748$ ) were most likely to agree

Additionally, only one statement of the community mental health ideology quadrant approached statistically significance numbers. Statement 31, which states that “residents should accept the location of mental health facilities in their neighborhoods to serve the needs of the local community,” approached significance at 0.058, revealing that those that willing attend one religious service per week ( $N=75$ ,  $M=3.51$ ,  $SD=0.665$ ) were the most likely to agree that residents should accept such facilities, while those that only occasionally attend religious services ( $N=17$ ,  $M=2.88$ ,  $SD=0.781$ ) were the most likely to disagree.

The significance correlated to religious involvement unveils some new information about how involvement may positively (or in some cases, negatively) impact perceptual sets. Much like the significance for gender, however, there is not enough correlation to similar statements in

quadrants or even statistical significance across quadrants. There are no known CAMI assessments that have examined variables of religious involvement.

Very few social distance-themed studies that focus on religious involvement exist. Two, however, have looked at this variable more closely. A study by Siltan and associates found that “[p]articipants who were younger, white, better educated and attended religious services more often required less social distance” than those that did not fit within those demographics (Siltan et al. 361). Similarly, Chung and Chan found that in a student sample, “students with religious beliefs were more accepting toward the target [mentally ill] individual associated with diagnostic label” (Chung and Chan 507). Ultimately, it seems that this research assessment did not produce results that correlate to previous research. In the current study, religious involvement was found *not* to play any role of significance in perception formation or desired social distance.

## Chapter 5- Limitations and Recommendations

This study sought to understand how gender and religious involvement impact latitudes of acceptance, rejection and non-commitment to statements about the mentally ill. Unfortunately, part of this research study has proven inconclusive. While ranges of participants' latitudes of acceptance, rejection and non-commitment were measured, adding to the scope of studies that have further validated Taylor and Dear's CAMI instrument, the areas of significance measured did not produce any verifiably significant information. Furthermore, it seems that Social Judgment Theory might not have been the best option for a theoretical framework for this study. Although the results are still valuable, the theoretical nature may be off base.

The sample pool used was a student sample of convenience, which might have significantly influenced the outcome of the results. Specifically, the student pool was gathered at a large, private, religiously-founded university, situated in the Mid-Atlantic region commonly referred to as the "Bible Belt." Students did not demonstrate a wide variety of religious association; thus, it may not have been appropriate to test for significance in this area. Christianity was the main religion noted, with little association outside of this. This may have impacted the study because it did not allow the researcher to compare the results against other religions, which could have yielded significance.

Additionally, denominational affiliation was measured. It seems that denomination would play a significant role in perceptual frameworks, but the method by which denominations were coded might have been faulty since it blended similar denominations into one, overarching group. Initially, participants were asked in an open ended format to indicate their denominational affiliation. Then, the researcher used these open-ended responses and coded them into similar groupings. For instance, participants that indicated "Baptist" as well as those that indicated

“Southern Baptist,” “Conservative Baptist,” “Primitive Baptist,” and any other Baptist-themed results were all merged into one group. It might have been more effective to provide close-ended options for denominations to participants and coded each on an individual level.

When asked to indicate their level of religious involvement, participants were provided with several options, including: (1) I willingly attend two or more religious services per week (non-required services), (2) I willingly attend one religious service per week (non-required services), (3) I attend one or more required religious services per week or attend other religious activities sporadically, (4) I occasionally attend a religious service, or (5) I am not religiously involved. As discussed in the literature review, a required religious service was relevant to the surveyed population since students were required to attend convocation services that occurred three times per week at the location surveyed.

This might have been confusing, however. It also might have impacted the results because if not clearly understood, students may have indicated a higher level of involvement than was true. Additionally, it did not account for the fact that students who live off campus are not required to attend such convocation services, thus the wording might have been confusing and irrelevant to some of the population. Granted, it does seem important to make a distinction between willing and required involvement, which this study attempted to do, yet in hindsight it might not be appropriate to measure religious involvement solely by physical church attendance. Online churches as well as private Bible studies and small groups are continuously impacting Christianity and it would have been wise to account for religious involvement that occurs outside the four walls of a physical building (Esselman; Hutchings).

The study also involved self-report. This might have skewed the results because it required participants to rank answers and, essentially, rank preferences of association with

certain groups. Participants might have selected answers that framed them in a more favorable light rather than select answers that reflect their true perceptions of the mental health community. The self-report might have also been impacted by the extra credit offered. Participants might have merely selected answers at random because the study had no real significance to their class or their grade. In order to receive extra credit points, participants were required to complete it, thus answers might not be true representations of the sample.

Perhaps one of the overarching limitations of this study is the integration of Social Judgment Theory. At first, it seems that Sherif's theory is an appropriate method to gather such data. As discussed, the scope of Social Judgment Theory rests on the viewpoints of individuals towards other people, groups or social issues. Sherif, Sherif and Nebergall assert that "an individual's attitude on an issue can be assessed adequately only if the procedures yield the limits of the position he accepts (latitude of acceptance) and the limits of positions he rejects (latitude of rejection), relative to the bounds of available alternatives defined by the extreme positions on the issue" (Sherif, Sherif and Nebergall 3). Additionally, Sherif asserts that individuals are often unwilling to commit to a certain issue, which is known as the latitude of non-commitment.

It seemed that Taylor and Dear's CAMI assessment would blend well with this because the use of a likert scale can measure degrees of agreement for sample populations. The initial argument for use of Social Judgment Theory was that the population could indicate their level of agreement, categorized by five different levels, and thus latitudes of acceptance, rejection and non-commitment would be evident for the entire population, with non-commitment being measured through the "N/A" option on the likert scale. Additionally, the theory recognizes that

outside forces influence attitudes and perceptions (such as gender and religious involvement); therefore, it seemed appropriate to use in this study.

This might not be an accurate representation of the bounds of Social Judgment Theory, however. As discussed in the literature review, Social Judgment Theory rests on scale of latitudes. The CAMI assessment did not allow participants to rank statements against each other for agreeability; rather, it forced participants to rank each statement individually. It is unclear if this fits exactly within the original framework of Social Judgment Theory and thus has implications on the interpretation of results.

Regardless, even if Social Judgment Theory is an inappropriate theoretical framework for this study, the results are still interesting. Future research can benefit from these results in a variety of ways. The goal of Sherif's theory is for individuals and practitioners from a variety of fields to be able to formulate arguments based on perceived levels of social judgment latitudes. This study does just that. Mental health professionals, scholars and other leaders can use data from studies such as this one to tailor anti-stigmatization messages for the general public. Taylor and Dear's instrument continues to provide valuable information and future research can benefit from its continued use.

Although Social Judgment Theory might not have been appropriately applied to this research study, future studies could glean knowledge from a proper application of Sherif's theory. Studies could use similar tools, but ask participants to rank statements in chronological order of agreement, similar to a Guttman assessment. This would allow researchers to adequately assess participants' latitudes of acceptance, rejection and non-commitment. Additionally, Sherif's theory could also show specific areas that mental health professionals can target to reduce stigma.

The social distance scale used revealed interesting information about participants' desired level of social involvement with the mentally ill, as well as other stigmatized groups. It might have been more appropriate to keep all social groups under one categorical umbrella, such as health-related groups (cancer patients, the mentally ill, etc.) or individual mental health diseases (schizophrenia, depression, bipolarism, etc.). In hindsight, other than the association of stigma, it does not seem appropriate to categorize the mentally ill and cancer patients (health-related groups) in the same category as illegal immigrants or convicted felons (groups bound by crimes committed). Future research can definitely benefit from social distance scales, but may find it beneficial to evaluate the groups used.

Future research could definitely benefit from a qualitative study. This quantitative information provides satisfactory data, but it does not account for the uniquely human experiences that influence perceptions. As discussed, the self-report survey used might not have yielded truthful results from all participants. A qualitative study could provide more detailed and rich information about perceptions of the mentally ill. Future studies could use focus groups or one on one interviews to understand more about participants' perceptions of the mental health community.

It may also be beneficial to gain insight into the how perceptions impact the mentally ill on a personal level. Many studies have examined stigma and are quick to point out its detrimental in a roundabout way, but do little to understand the impact that such stigma actually has on the mentally ill. A future study could examine, qualitatively or quantitatively, how the mentally ill perceived themselves in the social world and how they feel when they recognize stigma about mental illness.

As a whole, this study brings no new revelations or groundbreaking data. It does, however, reveal that more research must be conducted on the stigma that surrounds the mental health community. Gender and religious involvement proved to be insignificant variables in this study, but still deserve further analysis to see if these two variables have any true impact on perceptions of the mentally ill.

### *Conclusions*

In conclusion, this research project proved somewhat inclusive when testing for the variables of gender and religious involvement. **RQ1** questioned the latitudes of acceptance, rejection and non-commitment that participants had in their perceptions of the mentally ill. Although the terms associated with this research question are highly integrated with Social Judgment Theory, which has been questionably used, it seems that the results of the CAMI assessment show that participants have a wide range of accepting, rejecting and non-committed beliefs about the mentally ill. Overall, participants were more willing to cast a favorable light on the mentally ill. Even if participants did not frame a statement favorably, they were still more likely to not commit formally than they were to frame the mentally ill in a negative light.

**RQ2** and **RQ3** examined the variables of gender and religious involvement on perceptions of the mentally ill. This study shows that neither of these variables proved to be significantly associated with participants' beliefs about the mentally ill. Alas, other studies have found similar non-significant results, so this study is not in vain.

As a whole, regardless of no statistically-significant data emerging through this study, it still reveals much about the perceptual frameworks that individuals construct. It seems that characteristics such as gender and religious involvement would shape these perceptual constructs, but this study did not find that to be true. Social Judgment Theory—as well as

attitudes and perceptions in general—are highly integrated with individuals’ worldviews, thus it is important to continue studying how these worldviews impact perceptions.

Gender and religious involvement did not manifest as significant variables, which may render this study inconclusive or may reveal new thoughts about these variables. In an age of androgyny, perhaps men and women are becoming more integrated in more ways than physically. Future studies may reveal that gender is no longer as divisive a variable as it once was. Additionally, Christianity in particular has taken a decidedly social-looking stance in the last decade, with more and more Christian groups lobbying for social issues. This study may yield the results that it does because of the socially aware stance that has recently integrated with Christianity.

Aside from the variables, the results do reveal interesting themes about the sample and show, much like other studies, that perceptions of the mentally ill are always shifting and are not always consistent. Much like this study began, it seems important to note that stigmatizing attitudes toward the mentally ill are evident in a variety of outlets. Again, television and fictionalized accounts of mental illness are not always interested in providing an authentic account of such disease.

It seems that these fictional portrayals are being further debunked by studies, including this one, which clearly show that young individuals, students, males and females alike, are not necessarily influenced by these accounts. Whether through the social leanings of many religious groups or through any other variety of variables, this study shows that the “shock” value of the mentally ill that is portrayed in media accounts is not translating into stigma perpetuation. Perhaps, this is shocking in and of itself, and provides a glimmer of hope that the mentally ill

will one day distance themselves completely from the stigma that has been attached to their disease.

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## Appendix B

### *Community Attitudes of the Mentally Ill Scale (CAMI)*

Please rate your level of agreement to each of the following statements using the following numeric designations of agreement:

- 1- Strongly Disagree
- 2- Disagree
- 3- No Answer
- 4- Agree
- 5- Strongly Agree

1. One of the main causes of mental illness is a lack of self-discipline and will power
2. The best way to handle the mentally ill is to keep them behind locked doors
3. There is something about the mentally ill that makes it easy to tell them from normal people
4. As soon as a person shows signs of mental disturbance, he should be hospitalized
5. Mental patients need the same kind of control and discipline as a young child
6. Mental illness is an illness like any other
7. The mentally ill should not be treated as outcasts of society
8. Less emphasis should be placed on protecting the public from the mentally ill
9. Mental hospitals are an outdated means of treating the mentally ill
10. Virtually anyone can become mentally ill
11. The mentally ill have for too long been the subject of ridicule
12. More tax money should be spent on the care and treatment of the mentally ill
13. We need to adopt a far more tolerant attitude toward the mentally ill in our society
14. Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for
15. We have a responsibility to provide the best possible care for the mentally ill
16. The mentally ill don't deserve our sympathy
17. The mentally ill are a burden on society
18. Increased spending on mental health services is a waste of tax dollars
19. There are sufficient existing services for the mentally ill
20. It is best to avoid anyone who has mental problems
21. The mentally ill should not be given any responsibility
22. The mentally ill should be isolated from the rest of the community
23. A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered
24. I would not want to live next door to someone who has been mentally ill
25. Anyone with a history of mental problems should be excluded from taking public office
26. The mentally ill should not be denied their individual rights
27. Mental patients should be encouraged to assume the responsibilities of normal life
28. No one has the right to exclude the mentally ill from their neighborhood
29. The mentally ill are far less of a danger than most people suppose
30. Most women who were once patients in a mental hospital can be trusted as babysitters
31. Residents should accept the location of mental health facilities in their neighborhood to serve the needs of the local community
32. The best therapy for many mental patients is to be part of a normal community
33. As far as possible, mental health services should be provided through community-based facilities
34. Locating mental health services in residential neighborhoods does not endanger local residents

35. Residents have nothing to fear from people coming into their neighborhood to obtain mental health services
36. Mental health facilities should be kept out of residential neighborhoods
37. Local residents have good reason to resist the location of mental health services in their neighborhood
38. Having mental patients living within residential neighborhoods might be good therapy but the risks to residents are too great
39. It is frightening to think of people with mental problems living in residential neighborhoods
40. Locating mental health facilities in a residential area downgrades the neighborhood

## Appendix C

### *Bogardus' Social Distance Scale*

**Instructions:** Please check the boxes to indicate your level of comfortable association with each people group. If you do not agree, please do not check the box.

	<b>Cancer Patients</b>	<b>Convicted Felons</b>	<b>HIV Patients</b>	<b>Illegal Immigrants</b>	<b>Mentally Ill</b>
Would exclude from my country					
As visitors in my country					
As citizens in my country					
As co-workers in the same occupation					
As neighbors on the same street					
As my close personal friend					
As close relatives by marriage					

## Appendix D

### Consent Form

You have been invited to participate in a research study focusing on student perceptions of individuals with a mental health disease. You were selected based on your student status at a religious institution of higher learning. I respectfully request that you read this form in its entirety. Any and all questions should be addressed prior to your agreement to be involved in this study.

The purpose of this study is to understand the formation of perceptual sets surrounding the mental health community. Your agreement to participate in this study requires the following:

You will be asked a series of questions that attempt to assess perceptual frameworks in regard to the mental health community. Questions will assess basic demographic information, and will involve a social distance scale and a community attitude likert assessment.

As a whole, this study has minimal risks. You will be asked questions that may require recollection, references to the mentally ill and your relationships to such individuals, as well as your perceptions about those with a mental disease or defect. If you become uncomfortable at any point during the survey process, you may opt to stop the survey process.

You will receive 10 extra credit points for completing this survey packet. Please refer to the recruitment email that was forwarded to you by your professor or graduate student assistant for the specific guidelines on how to receive those extra credit points.

Liberty University is not responsible for providing medical treatment or financial compensation should you face any psychological trauma while participating in this survey. Please note that this does not waive any of your legal rights nor does it fail to acknowledge your right to a claim based on negligence.

These online surveys are completely anonymous and all surveys collected will be done so in a way that honors a commitment to personal confidentiality. Research will be stored until January 2017 (exactly five years from publication) in a private, locked safe box. At that time, it will be permanently destroyed.

Please note that your name, contact information and any incriminating information will not be discussed or disclosed to any other persons or institutions. Please do not enter personally identifiable information (name, social security number, address) in any of the answer portals of the online survey.

Your participation in this study is completely voluntary. Your participation will not in any way influence your current or future relations with Liberty University. If you choose to participate you reserve the right to withdraw from the study or decline to answer any questions that violate any personal values, attitudes or beliefs. Your decision to withdraw or decline information will not cause any strain on your relationships with Liberty University. If you choose to withdraw from the study, you may do so at anytime.

The researcher conducting this study is Phillip E. Wagner. Any and all questions should be directed to this researcher before the study is conducted. If questions still exist after the study, they should be directed to Phillip E. Wagner, (1) 4997 South Amherst Highway #313, Lynchburg, VA 24572, (2) 570-556-0789 or (3) [pewagner@liberty.edu](mailto:pewagner@liberty.edu). Additionally, Dr. Faith Mullen, chair of this thesis project can answer all questions on behalf of the researcher and can be reached at 433-592-7602 or at [fmullen@liberty.edu](mailto:fmullen@liberty.edu).

Any other questions or concerns regarding this study can be directed to the Dr. Fernando Garzon, Chair of the Institutional Review Board, 1971 University Boulevard, Suite 1582, Lynchburg, VA 24502 or [fgarzon@liberty.edu](mailto:fgarzon@liberty.edu).

Please print a copy of this information to keep for permanent records.

By participating in this survey, you agree that you have read and are accountable for all information in the above text. Please continue to access the survey.

## Appendix E- Tables and Analysis

**Table 1.L**  
**ANOVA (Gender)**

		Sum of Squares	df	Mean Square	F	Sig.
MI=Lack of Discipline	Between Groups	1.734	1	1.734	1.768	.185
	Within Groups	245.167	250	.981		
	Total	246.901	251			
Control= Locked Doors	Between Groups	.365	1	.365	.780	.378
	Within Groups	116.543	249	.468		
	Total	116.908	250			
MI are Distinguishable	Between Groups	2.651	1	2.651	2.575	.110
	Within Groups	251.203	244	1.030		
	Total	253.854	245			
Hospitalized	Between Groups	.103	1	.103	.124	.725
	Within Groups	204.693	247	.829		
	Total	204.795	248			
MI Child=Supervision	Between Groups	3.436	1	3.436	3.872	<b>.050</b>
	Within Groups	209.459	236	.888		
	Total	212.895	237			
Normal Disease	Between Groups	1.276	1	1.276	1.208	.273
	Within Groups	245.185	232	1.057		
	Total	246.462	233			
Not Outcasts	Between Groups	.969	1	.969	.638	.425
	Within Groups	376.875	248	1.520		
	Total	377.844	249			
Less Emphasis/Protection	Between Groups	1.498	1	1.498	1.603	.207
	Within Groups	232.702	249	.935		
	Total	234.199	250			

Mhospitals Outdated	Between Groups	.141	1	.141	.167	.683
	Within Groups	207.214	246	.842		
	Total	207.355	247			
Anyone Can be MI	Between Groups	3.164	1	3.164	3.217	<b>.074</b>
	Within Groups	242.964	247	.984		
	Total	246.129	248			
Too Much Ridicule	Between Groups	.095	1	.095	.112	.738
	Within Groups	209.449	246	.851		
	Total	209.544	247			
MI=More Tax Money	Between Groups	.120	1	.120	.141	.707
	Within Groups	211.096	248	.851		
	Total	211.216	249			
Need More Tolerance	Between Groups	.063	1	.063	.078	.781
	Within Groups	201.124	250	.804		
	Total	201.187	251			
Minst=Prison	Between Groups	.001	1	.001	.001	.976
	Within Groups	219.135	248	.884		
	Total	219.136	249			
Responsibility	Between Groups	.796	1	.796	.949	.331
	Within Groups	209.617	250	.838		
	Total	210.413	251			
No sympathy	Between Groups	.842	1	.842	1.313	.253
	Within Groups	159.700	249	.641		
	Total	160.542	250			
MI= Burden	Between Groups	2.205	1	2.205	2.849	<b>.093</b>
	Within Groups	192.735	249	.774		
	Total	194.940	250			

Waste of Tax Money	Between Groups	.028	1	.028	.031	.861
	Within Groups	228.696	248	.922		
	Total	228.724	249			
Enough Services	Between Groups	.003	1	.003	.005	.946
	Within Groups	174.889	249	.702		
	Total	174.892	250			
Avoid MI	Between Groups	.168	1	.168	.312	.577
	Within Groups	134.483	250	.538		
	Total	134.651	251			
No MI Responsibility	Between Groups	.183	1	.183	.233	.630
	Within Groups	195.379	249	.785		
	Total	195.562	250			
Isolated	Between Groups	1.042	1	1.042	1.836	.177
	Within Groups	140.734	248	.567		
	Total	141.776	249			
Marriage foolish	Between Groups	1.549	1	1.549	2.114	.147
	Within Groups	182.388	249	.732		
	Total	183.936	250			
Not Neighbors	Between Groups	.866	1	.866	.882	.348
	Within Groups	243.358	248	.981		
	Total	244.224	249			
No Public Office	Between Groups	.200	1	.200	.164	.686
	Within Groups	303.433	249	1.219		
	Total	303.633	250			
Keep Rights	Between Groups	4.307	1	4.307	3.185	<b>.076</b>
	Within Groups	333.942	247	1.352		
	Total	338.249	248			

MI should have responsibility	Between Groups	.000	1	.000	.000	.992
	Within Groups	222.678	250	.891		
	Total	222.679	251			
MI have neighborhood rights	Between Groups	.002	1	.002	.002	.962
	Within Groups	229.217	249	.921		
	Total	229.219	250			
MI Less Dangerous	Between Groups	.018	1	.018	.022	.883
	Within Groups	203.395	250	.814		
	Total	203.413	251			
Women MI as Babysitters	Between Groups	.206	1	.206	.277	.599
	Within Groups	184.530	248	.744		
	Total	184.736	249			
MIF should be accepted	Between Groups	.595	1	.595	.896	.345
	Within Groups	166.056	250	.664		
	Total	166.651	251			
MI need community	Between Groups	.905	1	.905	1.305	.254
	Within Groups	172.760	249	.694		
	Total	173.665	250			
MIF should be community serviced	Between Groups	.010	1	.010	.015	.904
	Within Groups	166.723	249	.670		
	Total	166.733	250			
MIF no threat	Between Groups	.034	1	.034	.047	.828
	Within Groups	178.962	249	.719		
	Total	178.996	250			
Residents shouldn't fear MI	Between Groups	.033	1	.033	.043	.836
	Within Groups	191.396	250	.766		
	Total	191.429	251			
MIF not in Res Nhoods	Between Groups	3.932	1	3.932	4.749	<b>.030</b>

	Within Groups	206.957	250	.828		
	Total	210.889	251			
Right to Resist	Between Groups	1.798	1	1.798	2.403	.122
	Within Groups	187.103	250	.748		
	Total	188.901	251			
Risks to great for LMHI	Between Groups	2.036	1	2.036	2.269	.133
	Within Groups	223.398	249	.897		
	Total	225.434	250			
MHI in RN is frightening	Between Groups	.094	1	.094	.114	.736
	Within Groups	205.929	249	.827		
	Total	206.024	250			
MHI downgrades NH	Between Groups	.297	1	.297	.337	.562
	Within Groups	212.378	241	.881		
	Total	212.675	242			

**Table 1.M**  
**ANOVA (Involvement)**

		Sum of Squares	df	Mean Square	F	Sig.
MI=Lack of Discipline	Between Groups	5.724	4	1.431	1.465	.213
	Within Groups	241.177	247	.976		
	Total	246.901	251			
Control= Locked Doors	Between Groups	1.284	4	.321	.683	.604
	Within Groups	115.624	246	.470		
	Total	116.908	250			
MI are Distinguishable	Between Groups	1.049	4	.262	.250	.909
	Within Groups	252.805	241	1.049		
	Total	253.854	245			
Hospitalized	Between Groups	6.891	4	1.723	2.124	<b>.078</b>
	Within Groups	197.904	244	.811		
	Total	204.795	248			
MI Child=Supervision	Between Groups	1.456	4	.364	.401	.808
	Within Groups	211.439	233	.907		
	Total	212.895	237			
Normal Disease	Between Groups	4.142	4	1.036	.979	.420
	Within Groups	242.320	229	1.058		
	Total	246.462	233			
Not Outcasts	Between Groups	2.851	4	.713	.466	.761
	Within Groups	374.993	245	1.531		
	Total	377.844	249			
Less Emphasis/Protection	Between Groups	.582	4	.145	.153	.961
	Within Groups	233.618	246	.950		
	Total	234.199	250			

Mhospitals Outdated	Between Groups	3.293	4	.823	.980	.419
	Within Groups	204.062	243	.840		
	Total	207.355	247			
Anyone Can be MI	Between Groups	6.818	4	1.705	1.738	.142
	Within Groups	239.310	244	.981		
	Total	246.129	248			
Too Much Ridicule	Between Groups	.795	4	.199	.231	.921
	Within Groups	208.750	243	.859		
	Total	209.544	247			
MI=More Tax Money	Between Groups	1.058	4	.265	.308	.872
	Within Groups	210.158	245	.858		
	Total	211.216	249			
Need More Tolerance	Between Groups	1.659	4	.415	.513	.726
	Within Groups	199.527	247	.808		
	Total	201.187	251			
Minst=Prison	Between Groups	2.488	4	.622	.703	.590
	Within Groups	216.648	245	.884		
	Total	219.136	249			
Responsibility	Between Groups	2.265	4	.566	.672	.612
	Within Groups	208.148	247	.843		
	Total	210.413	251			
No sympathy	Between Groups	1.535	4	.384	.594	.667
	Within Groups	159.007	246	.646		
	Total	160.542	250			
MI= Burden	Between Groups	5.611	4	1.403	1.823	.125
	Within Groups	189.329	246	.770		
	Total	194.940	250			

Waste of Tax Money	Between Groups	3.594	4	.899	.978	.420
	Within Groups	225.130	245	.919		
	Total	228.724	249			
Enough Services	Between Groups	1.522	4	.381	.540	.706
	Within Groups	173.370	246	.705		
	Total	174.892	250			
Avoid MI	Between Groups	1.945	4	.486	.905	.461
	Within Groups	132.705	247	.537		
	Total	134.651	251			
No MI Responsibility	Between Groups	.471	4	.118	.149	.963
	Within Groups	195.090	246	.793		
	Total	195.562	250			
Isolated	Between Groups	.557	4	.139	.241	.915
	Within Groups	141.219	245	.576		
	Total	141.776	249			
Marriage foolish	Between Groups	6.031	4	1.508	2.085	<b>.083</b>
	Within Groups	177.905	246	.723		
	Total	183.936	250			
Not Neighbors	Between Groups	.629	4	.157	.158	.959
	Within Groups	243.595	245	.994		
	Total	244.224	249			
No Public Office	Between Groups	.880	4	.220	.179	.949
	Within Groups	302.753	246	1.231		
	Total	303.633	250			
Keep Rights	Between Groups	8.190	4	2.047	1.514	.199
	Within Groups	330.059	244	1.353		
	Total	338.249	248			

MI should have responsibility	Between Groups	2.191	4	.548	.614	.653
	Within Groups	220.487	247	.893		
	Total	222.679	251			
MI have neighborhood rights	Between Groups	2.035	4	.509	.551	.699
	Within Groups	227.184	246	.924		
	Total	229.219	250			
MI Less Dangerous	Between Groups	1.136	4	.284	.347	.846
	Within Groups	202.277	247	.819		
	Total	203.413	251			
Women MI as Babysitters	Between Groups	4.531	4	1.133	1.540	.191
	Within Groups	180.205	245	.736		
	Total	184.736	249			
MIF should be accepted	Between Groups	6.027	4	1.507	2.317	<b>.058</b>
	Within Groups	160.624	247	.650		
	Total	166.651	251			
MI need community	Between Groups	1.935	4	.484	.693	.597
	Within Groups	171.730	246	.698		
	Total	173.665	250			
MIF should be community serviced	Between Groups	.936	4	.234	.347	.846
	Within Groups	165.797	246	.674		
	Total	166.733	250			
MIF no threat	Between Groups	4.496	4	1.124	1.584	.179
	Within Groups	174.500	246	.709		
	Total	178.996	250			
Residents shouldn't fear MI	Between Groups	3.953	4	.988	1.302	.270
	Within Groups	187.476	247	.759		
	Total	191.429	251			

MIF not in Res Nhoods	Between Groups	6.252	4	1.563	1.887	.113
	Within Groups	204.636	247	.828		
	Total	210.889	251			
Right to Resist	Between Groups	4.244	4	1.061	1.419	.228
	Within Groups	184.657	247	.748		
	Total	188.901	251			
Risks to great for LMHI	Between Groups	4.471	4	1.118	1.244	.293
	Within Groups	220.963	246	.898		
	Total	225.434	250			
MHI in RN is frightening	Between Groups	3.710	4	.927	1.128	.344
	Within Groups	202.314	246	.822		
	Total	206.024	250			
MHI downgrades NH	Between Groups	6.107	4	1.527	1.759	.138
	Within Groups	206.568	238	.868		
	Total	212.675	242			

**Table 1. N (Race)  
ANOVA**

		Sum of Squares	df	Mean Square	F	Sig.
MI=Lack of Discipline	Between Groups	4.899	6	.816	.826	.551
	Within Groups	241.173	244	.988		
	Total	246.072	250			
Control= Locked Doors	Between Groups	3.659	6	.610	1.310	.253
	Within Groups	113.077	243	.465		
	Total	116.736	249			
MI are Distinguishable	Between Groups	1.465	6	.244	.230	.967
	Within Groups	252.388	238	1.060		
	Total	253.853	244			
Hospitalized	Between Groups	.830	6	.138	.164	.986
	Within Groups	203.944	241	.846		
	Total	204.774	247			
MI Child=Supervision	Between Groups	4.966	6	.828	.920	.481
	Within Groups	206.966	230	.900		
	Total	211.932	236			
Normal Disease	Between Groups	9.172	6	1.529	1.460	.193
	Within Groups	236.570	226	1.047		
	Total	245.742	232			
Not Outcasts	Between Groups	17.671	6	2.945	1.984	<b>.069</b>
	Within Groups	359.301	242	1.485		
	Total	376.972	248			
Less Emphasis/Protection	Between Groups	1.444	6	.241	.257	.956
	Within Groups	227.952	243	.938		
	Total	229.396	249			

Mhospitals Outdated	Between Groups	7.760	6	1.293	1.555	.161
	Within Groups	199.544	240	.831		
	Total	207.304	246			
Anyone Can be MI	Between Groups	5.273	6	.879	.880	.510
	Within Groups	240.582	241	.998		
	Total	245.855	247			
Too Much Ridicule	Between Groups	8.506	6	1.418	1.704	.121
	Within Groups	199.656	240	.832		
	Total	208.162	246			
MI=More Tax Money	Between Groups	6.599	6	1.100	1.308	.254
	Within Groups	203.497	242	.841		
	Total	210.096	248			
Need More Tolerance	Between Groups	8.000	6	1.333	1.695	.123
	Within Groups	191.920	244	.787		
	Total	199.920	250			
Minst=Prison	Between Groups	10.562	6	1.760	2.044	<b>.061</b>
	Within Groups	208.426	242	.861		
	Total	218.988	248			
Responsibility	Between Groups	4.314	6	.719	.856	.528
	Within Groups	204.929	244	.840		
	Total	209.243	250			
No sympathy	Between Groups	4.559	6	.760	1.187	.314
	Within Groups	155.585	243	.640		
	Total	160.144	249			
MI= Burden	Between Groups	3.811	6	.635	.811	.562
	Within Groups	190.413	243	.784		
	Total	194.224	249			

Waste of Tax Money	Between Groups	4.912	6	.819	.892	.501
	Within Groups	221.988	242	.917		
	Total	226.900	248			
Enough Services	Between Groups	.960	6	.160	.225	.969
	Within Groups	173.104	243	.712		
	Total	174.064	249			
Avoid MI	Between Groups	2.892	6	.482	.897	.498
	Within Groups	131.164	244	.538		
	Total	134.056	250			
No MI Responsibility	Between Groups	3.533	6	.589	.745	.614
	Within Groups	192.023	243	.790		
	Total	195.556	249			
Isolated	Between Groups	4.708	6	.785	1.390	.219
	Within Groups	136.626	242	.565		
	Total	141.333	248			
Marriage foolish	Between Groups	3.784	6	.631	.856	.528
	Within Groups	179.116	243	.737		
	Total	182.900	249			
Not Neighbors	Between Groups	3.318	6	.553	.559	.763
	Within Groups	239.573	242	.990		
	Total	242.892	248			
No Public Office	Between Groups	3.944	6	.657	.534	.782
	Within Groups	299.000	243	1.230		
	Total	302.944	249			
Keep Rights	Between Groups	4.562	6	.760	.563	.760
	Within Groups	325.616	241	1.351		
	Total	330.177	247			

MI should have responsibility	Between Groups	4.642	6	.774	.866	.520
	Within Groups	217.947	244	.893		
	Total	222.590	250			
MI have neighborhood rights	Between Groups	6.025	6	1.004	1.099	.364
	Within Groups	222.075	243	.914		
	Total	228.100	249			
MI Less Dangerous	Between Groups	9.068	6	1.511	1.957	<b>.073</b>
	Within Groups	188.462	244	.772		
	Total	197.530	250			
Women MI as Babysitters	Between Groups	2.549	6	.425	.565	.758
	Within Groups	181.845	242	.751		
	Total	184.394	248			
MIF should be accepted	Between Groups	5.960	6	.993	1.512	.175
	Within Groups	160.255	244	.657		
	Total	166.215	250			
MI need community	Between Groups	3.054	6	.509	.734	.623
	Within Groups	168.546	243	.694		
	Total	171.600	249			
MIF should be community serviced	Between Groups	1.670	6	.278	.411	.872
	Within Groups	164.714	243	.678		
	Total	166.384	249			
MIF no threat	Between Groups	4.962	6	.827	1.155	.331
	Within Groups	174.034	243	.716		
	Total	178.996	249			
Residents shouldn't fear MI	Between Groups	3.270	6	.545	.710	.642
	Within Groups	187.248	244	.767		
	Total	190.518	250			

MIF not in Res Nhoods	Between Groups	6.568	6	1.095	1.312	.252
	Within Groups	203.527	244	.834		
	Total	210.096	250			
Right to Resist	Between Groups	2.109	6	.352	.462	.836
	Within Groups	185.596	244	.761		
	Total	187.705	250			
Risks to great for LMHI	Between Groups	1.523	6	.254	.276	.948
	Within Groups	223.261	243	.919		
	Total	224.784	249			
MHI in RN is frightening	Between Groups	2.005	6	.334	.403	.877
	Within Groups	201.595	243	.830		
	Total	203.600	249			
MHI downgrades NH	Between Groups	2.719	6	.453	.509	.802
	Within Groups	209.380	235	.891		
	Total	212.099	241			

**Table 1.O (Religion)  
ANOVA**

		Sum of Squares	df	Mean Square	F	Sig.
MI=Lack of Discipline	Between Groups	3.186	3	1.062	1.081	.358
	Within Groups	243.715	248	.983		
	Total	246.901	251			
Control= Locked Doors	Between Groups	.876	3	.292	.621	.602
	Within Groups	116.033	247	.470		
	Total	116.908	250			
MI are Distinguishable	Between Groups	1.503	3	.501	.480	.696
	Within Groups	252.351	242	1.043		
	Total	253.854	245			
Hospitalized	Between Groups	4.992	3	1.664	2.040	.109
	Within Groups	199.803	245	.816		
	Total	204.795	248			
MI Child=Supervision	Between Groups	1.002	3	.334	.369	.775
	Within Groups	211.893	234	.906		
	Total	212.895	237			
Normal Disease	Between Groups	4.267	3	1.422	1.351	.259
	Within Groups	242.194	230	1.053		
	Total	246.462	233			
Not Outcasts	Between Groups	2.144	3	.715	.468	.705
	Within Groups	375.700	246	1.527		
	Total	377.844	249			
Less Emphasis/Protection	Between Groups	.301	3	.100	.106	.957
	Within Groups	233.898	247	.947		
	Total	234.199	250			

Mhospitals Outdated	Between Groups	.260	3	.087	.102	.959
	Within Groups	207.095	244	.849		
	Total	207.355	247			
Anyone Can be MI	Between Groups	1.002	3	.334	.334	.801
	Within Groups	245.127	245	1.001		
	Total	246.129	248			
Too Much Ridicule	Between Groups	1.011	3	.337	.394	.757
	Within Groups	208.533	244	.855		
	Total	209.544	247			
MI=More Tax Money	Between Groups	1.261	3	.420	.492	.688
	Within Groups	209.955	246	.853		
	Total	211.216	249			
Need More Tolerance	Between Groups	1.595	3	.532	.661	.577
	Within Groups	199.591	248	.805		
	Total	201.187	251			
Minst=Prison	Between Groups	3.436	3	1.145	1.306	.273
	Within Groups	215.700	246	.877		
	Total	219.136	249			
Responsibility	Between Groups	3.054	3	1.018	1.218	.304
	Within Groups	207.358	248	.836		
	Total	210.413	251			
No sympathy	Between Groups	.469	3	.156	.241	.868
	Within Groups	160.073	247	.648		
	Total	160.542	250			
MI= Burden	Between Groups	1.005	3	.335	.427	.734
	Within Groups	193.935	247	.785		
	Total	194.940	250			

Waste of Tax Money	Between Groups	2.412	3	.804	.874	.455
	Within Groups	226.312	246	.920		
	Total	228.724	249			
Enough Services	Between Groups	2.234	3	.745	1.065	.364
	Within Groups	172.659	247	.699		
	Total	174.892	250			
Avoid MI	Between Groups	1.805	3	.602	1.123	.340
	Within Groups	132.846	248	.536		
	Total	134.651	251			
No MI Responsibility	Between Groups	.688	3	.229	.291	.832
	Within Groups	194.874	247	.789		
	Total	195.562	250			
Isolated	Between Groups	1.556	3	.519	.910	.437
	Within Groups	140.220	246	.570		
	Total	141.776	249			
Marriage foolish	Between Groups	.538	3	.179	.241	.867
	Within Groups	183.398	247	.743		
	Total	183.936	250			
Not Neighbors	Between Groups	2.932	3	.977	.996	.395
	Within Groups	241.292	246	.981		
	Total	244.224	249			
No Public Office	Between Groups	1.638	3	.546	.446	.720
	Within Groups	301.996	247	1.223		
	Total	303.633	250			
Keep Rights	Between Groups	.806	3	.269	.195	.900
	Within Groups	337.443	245	1.377		
	Total	338.249	248			

MI should have responsibility	Between Groups	2.349	3	.783	.881	.451
	Within Groups	220.330	248	.888		
	Total	222.679	251			
MI have neighborhood rights	Between Groups	2.134	3	.711	.774	.510
	Within Groups	227.085	247	.919		
	Total	229.219	250			
MI Less Dangerous	Between Groups	1.534	3	.511	.628	.597
	Within Groups	201.879	248	.814		
	Total	203.413	251			
Women MI as Babysitters	Between Groups	4.373	3	1.458	1.988	.116
	Within Groups	180.363	246	.733		
	Total	184.736	249			
MIF should be accepted	Between Groups	1.041	3	.347	.520	.669
	Within Groups	165.609	248	.668		
	Total	166.651	251			
MI need community	Between Groups	2.352	3	.784	1.131	.337
	Within Groups	171.313	247	.694		
	Total	173.665	250			
MIF should be community serviced	Between Groups	.201	3	.067	.099	.960
	Within Groups	166.533	247	.674		
	Total	166.733	250			
MIF no threat	Between Groups	3.533	3	1.178	1.658	.177
	Within Groups	175.463	247	.710		
	Total	178.996	250			
Residents shouldn't fear MI	Between Groups	3.688	3	1.229	1.624	.184
	Within Groups	187.741	248	.757		
	Total	191.429	251			

MIF not in Res Nhoods	Between Groups	1.840	3	.613	.728	.536
	Within Groups	209.049	248	.843		
	Total	210.889	251			
Right to Resist	Between Groups	1.542	3	.514	.681	.565
	Within Groups	187.358	248	.755		
	Total	188.901	251			
Risks to great for LMHI	Between Groups	.300	3	.100	.110	.954
	Within Groups	225.134	247	.911		
	Total	225.434	250			
MHI in RN is frightening	Between Groups	.939	3	.313	.377	.770
	Within Groups	205.085	247	.830		
	Total	206.024	250			
MHI downgrades NH	Between Groups	2.826	3	.942	1.073	.361
	Within Groups	209.849	239	.878		
	Total	212.675	242			

**Table 1.P (Denomination)  
ANOVA**

		Sum of Squares	df	Mean Square	F	Sig.
MI=Lack of Discipline	Between Groups	3.186	3	1.062	1.081	.358
	Within Groups	243.715	248	.983		
	Total	246.901	251			
Control= Locked Doors	Between Groups	.876	3	.292	.621	.602
	Within Groups	116.033	247	.470		
	Total	116.908	250			
MI are Distinguishable	Between Groups	1.503	3	.501	.480	.696
	Within Groups	252.351	242	1.043		
	Total	253.854	245			
Hospitalized	Between Groups	4.992	3	1.664	2.040	.109
	Within Groups	199.803	245	.816		
	Total	204.795	248			
MI Child=Supervision	Between Groups	1.002	3	.334	.369	.775
	Within Groups	211.893	234	.906		
	Total	212.895	237			
Normal Disease	Between Groups	4.267	3	1.422	1.351	.259
	Within Groups	242.194	230	1.053		
	Total	246.462	233			
Not Outcasts	Between Groups	2.144	3	.715	.468	.705
	Within Groups	375.700	246	1.527		
	Total	377.844	249			

Less Emphasis/Protection	Between Groups	.301	3	.100	.106	.957
	Within Groups	233.898	247	.947		
	Total	234.199	250			
Mhospitals Outdated	Between Groups	.260	3	.087	.102	.959
	Within Groups	207.095	244	.849		
	Total	207.355	247			
Anyone Can be MI	Between Groups	1.002	3	.334	.334	.801
	Within Groups	245.127	245	1.001		
	Total	246.129	248			
Too Much Ridicule	Between Groups	1.011	3	.337	.394	.757
	Within Groups	208.533	244	.855		
	Total	209.544	247			
MI=More Tax Money	Between Groups	1.261	3	.420	.492	.688
	Within Groups	209.955	246	.853		
	Total	211.216	249			
Need More Tolerance	Between Groups	1.595	3	.532	.661	.577
	Within Groups	199.591	248	.805		
	Total	201.187	251			
Minst=Prison	Between Groups	3.436	3	1.145	1.306	.273
	Within Groups	215.700	246	.877		
	Total	219.136	249			
Responsibility	Between Groups	3.054	3	1.018	1.218	.304
	Within Groups	207.358	248	.836		
	Total	210.413	251			
No sympathy	Between Groups	.469	3	.156	.241	.868
	Within Groups	160.073	247	.648		
	Total	160.542	250			

MI= Burden	Between Groups	1.005	3	.335	.427	.734
	Within Groups	193.935	247	.785		
	Total	194.940	250			
Waste of Tax Money	Between Groups	2.412	3	.804	.874	.455
	Within Groups	226.312	246	.920		
	Total	228.724	249			
Enough Services	Between Groups	2.234	3	.745	1.065	.364
	Within Groups	172.659	247	.699		
	Total	174.892	250			
Avoid MI	Between Groups	1.805	3	.602	1.123	.340
	Within Groups	132.846	248	.536		
	Total	134.651	251			
No MI Responsibility	Between Groups	.688	3	.229	.291	.832
	Within Groups	194.874	247	.789		
	Total	195.562	250			
Isolated	Between Groups	1.556	3	.519	.910	.437
	Within Groups	140.220	246	.570		
	Total	141.776	249			
Marriage foolish	Between Groups	.538	3	.179	.241	.867
	Within Groups	183.398	247	.743		
	Total	183.936	250			
Not Neighbors	Between Groups	2.932	3	.977	.996	.395
	Within Groups	241.292	246	.981		
	Total	244.224	249			
No Public Office	Between Groups	1.638	3	.546	.446	.720
	Within Groups	301.996	247	1.223		
	Total	303.633	250			

Keep Rights	Between Groups	.806	3	.269	.195	.900
	Within Groups	337.443	245	1.377		
	Total	338.249	248			
MI should have responsibility	Between Groups	2.349	3	.783	.881	.451
	Within Groups	220.330	248	.888		
	Total	222.679	251			
MI have neighborhood rights	Between Groups	2.134	3	.711	.774	.510
	Within Groups	227.085	247	.919		
	Total	229.219	250			
MI Less Dangerous	Between Groups	1.534	3	.511	.628	.597
	Within Groups	201.879	248	.814		
	Total	203.413	251			
Women MI as Babysitters	Between Groups	4.373	3	1.458	1.988	.116
	Within Groups	180.363	246	.733		
	Total	184.736	249			
MIF should be accepted	Between Groups	1.041	3	.347	.520	.669
	Within Groups	165.609	248	.668		
	Total	166.651	251			
MI need community	Between Groups	2.352	3	.784	1.131	.337
	Within Groups	171.313	247	.694		
	Total	173.665	250			
MIF should be community serviced	Between Groups	.201	3	.067	.099	.960
	Within Groups	166.533	247	.674		
	Total	166.733	250			
MIF no threat	Between Groups	3.533	3	1.178	1.658	.177
	Within Groups	175.463	247	.710		
	Total	178.996	250			

Residents shouldn't fear MI	Between Groups	3.688	3	1.229	1.624	.184
	Within Groups	187.741	248	.757		
	Total	191.429	251			
MIF not in Res Nhoods	Between Groups	1.840	3	.613	.728	.536
	Within Groups	209.049	248	.843		
	Total	210.889	251			
Right to Resist	Between Groups	1.542	3	.514	.681	.565
	Within Groups	187.358	248	.755		
	Total	188.901	251			
Risks to great for LMHI	Between Groups	.300	3	.100	.110	.954
	Within Groups	225.134	247	.911		
	Total	225.434	250			
MHI in RN is frightening	Between Groups	.939	3	.313	.377	.770
	Within Groups	205.085	247	.830		
	Total	206.024	250			
MHI downgrades NH	Between Groups	2.826	3	.942	1.073	.361
	Within Groups	209.849	239	.878		
	Total	212.675	242			

**Table 1.Q (Political Association)  
ANOVA**

		Sum of Squares	df	Mean Square	F	Sig.
MI=Lack of Discipline	Between Groups	5.461	3	1.820	1.870	.135
	Within Groups	241.440	248	.974		
	Total	246.901	251			
Control= Locked Doors	Between Groups	2.125	3	.708	1.524	.209
	Within Groups	114.784	247	.465		
	Total	116.908	250			
MI are Distinguishable	Between Groups	1.523	3	.508	.487	.692
	Within Groups	252.331	242	1.043		
	Total	253.854	245			
Hospitalized	Between Groups	3.669	3	1.223	1.490	.218
	Within Groups	201.126	245	.821		
	Total	204.795	248			
MI Child=Supervision	Between Groups	1.586	3	.529	.585	.625
	Within Groups	211.309	234	.903		
	Total	212.895	237			
Normal Disease	Between Groups	6.673	3	2.224	2.134	<b>.097</b>
	Within Groups	239.788	230	1.043		
	Total	246.462	233			
Not Outcasts	Between Groups	3.866	3	1.289	.848	.469
	Within Groups	373.978	246	1.520		
	Total	377.844	249			
Less Emphasis/Protection	Between Groups	6.898	3	2.299	2.499	<b>.060</b>
	Within Groups	227.301	247	.920		
	Total	234.199	250			

Mhospitals Outdated	Between Groups	3.374	3	1.125	1.345	.260
	Within Groups	203.980	244	.836		
	Total	207.355	247			
Anyone Can be MI	Between Groups	4.540	3	1.513	1.535	.206
	Within Groups	241.588	245	.986		
	Total	246.129	248			
Too Much Ridicule	Between Groups	.102	3	.034	.040	.989
	Within Groups	209.442	244	.858		
	Total	209.544	247			
MI=More Tax Money	Between Groups	1.621	3	.540	.634	.594
	Within Groups	209.595	246	.852		
	Total	211.216	249			
Need More Tolerance	Between Groups	6.421	3	2.140	2.725	<b>.045</b>
	Within Groups	194.766	248	.785		
	Total	201.187	251			
Minst=Prison	Between Groups	10.625	3	3.542	4.178	<b>.007</b>
	Within Groups	208.511	246	.848		
	Total	219.136	249			
Responsibility	Between Groups	4.589	3	1.530	1.843	.140
	Within Groups	205.824	248	.830		
	Total	210.413	251			
No sympathy	Between Groups	.676	3	.225	.348	.791
	Within Groups	159.866	247	.647		
	Total	160.542	250			
MI= Burden	Between Groups	.303	3	.101	.128	.943
	Within Groups	194.637	247	.788		
	Total	194.940	250			

Waste of Tax Money	Between Groups	3.839	3	1.280	1.400	.243
	Within Groups	224.885	246	.914		
	Total	228.724	249			
Enough Services	Between Groups	3.107	3	1.036	1.489	.218
	Within Groups	171.785	247	.695		
	Total	174.892	250			
Avoid MI	Between Groups	.666	3	.222	.411	.745
	Within Groups	133.984	248	.540		
	Total	134.651	251			
No MI Responsibility	Between Groups	.765	3	.255	.323	.808
	Within Groups	194.797	247	.789		
	Total	195.562	250			
Isolated	Between Groups	.573	3	.191	.333	.802
	Within Groups	141.203	246	.574		
	Total	141.776	249			
Marriage foolish	Between Groups	3.088	3	1.029	1.406	.242
	Within Groups	180.848	247	.732		
	Total	183.936	250			
Not Neighbors	Between Groups	4.359	3	1.453	1.490	.218
	Within Groups	239.865	246	.975		
	Total	244.224	249			
No Public Office	Between Groups	16.856	3	5.619	4.839	<b>.003</b>
	Within Groups	286.778	247	1.161		
	Total	303.633	250			
Keep Rights	Between Groups	4.377	3	1.459	1.071	.362
	Within Groups	333.872	245	1.363		
	Total	338.249	248			

MI should have responsibility	Between Groups	3.018	3	1.006	1.136	.335
	Within Groups	219.660	248	.886		
	Total	222.679	251			
MI have neighborhood rights	Between Groups	1.089	3	.363	.393	.758
	Within Groups	228.130	247	.924		
	Total	229.219	250			
MI Less Dangerous	Between Groups	10.998	3	3.666	4.725	<b>.003</b>
	Within Groups	192.415	248	.776		
	Total	203.413	251			
Women MI as Babysitters	Between Groups	1.917	3	.639	.860	.463
	Within Groups	182.819	246	.743		
	Total	184.736	249			
MIF should be accepted	Between Groups	3.157	3	1.052	1.596	.191
	Within Groups	163.494	248	.659		
	Total	166.651	251			
MI need community	Between Groups	.947	3	.316	.451	.717
	Within Groups	172.719	247	.699		
	Total	173.665	250			
MIF should be community serviced	Between Groups	5.572	3	1.857	2.846	<b>.038</b>
	Within Groups	161.161	247	.652		
	Total	166.733	250			
MIF no threat	Between Groups	5.911	3	1.970	2.812	<b>.040</b>
	Within Groups	173.085	247	.701		
	Total	178.996	250			
Residents shouldn't fear MI	Between Groups	2.845	3	.948	1.247	.293
	Within Groups	188.583	248	.760		
	Total	191.429	251			

MIF not in Res Nhoods	Between Groups	1.791	3	.597	.708	.548
	Within Groups	209.097	248	.843		
	Total	210.889	251			
Right to Resist	Between Groups	.366	3	.122	.161	.923
	Within Groups	188.534	248	.760		
	Total	188.901	251			
Risks to great for LMHI	Between Groups	1.315	3	.438	.483	.694
	Within Groups	224.119	247	.907		
	Total	225.434	250			
MHI in RN is frightening	Between Groups	.944	3	.315	.379	.768
	Within Groups	205.080	247	.830		
	Total	206.024	250			
MHI downgrades NH	Between Groups	1.525	3	.508	.575	.632
	Within Groups	211.150	239	.883		
	Total	212.675	242			

**Table 1.R (Disease Relationship)  
ANOVA**

		Sum of Squares	df	Mean Square	F	Sig.
MI=Lack of Discipline	Between Groups	.015	1	.015	.015	.901
	Within Groups	234.022	244	.959		
	Total	234.037	245			
Control= Locked Doors	Between Groups	.166	1	.166	.350	.555
	Within Groups	115.532	243	.475		
	Total	115.698	244			
MI are Distinguishable	Between Groups	.015	1	.015	.015	.903
	Within Groups	245.968	238	1.033		
	Total	245.983	239			
Hospitalized	Between Groups	.451	1	.451	.547	.460
	Within Groups	198.792	241	.825		
	Total	199.243	242			
MI Child=Supervision	Between Groups	1.672	1	1.672	1.856	.174
	Within Groups	208.173	231	.901		
	Total	209.845	232			
Normal Disease	Between Groups	.104	1	.104	.098	.754
	Within Groups	240.254	227	1.058		
	Total	240.358	228			
Not Outcasts	Between Groups	2.544	1	2.544	1.700	.194
	Within Groups	362.128	242	1.496		
	Total	364.672	243			
Less Emphasis/Protection	Between Groups	3.913	1	3.913	4.216	<b>.041</b>
	Within Groups	225.540	243	.928		
	Total	229.453	244			

Mhospitals Outdated	Between Groups	.914	1	.914	1.086	.298
	Within Groups	202.716	241	.841		
	Total	203.630	242			
Anyone Can be MI	Between Groups	1.190	1	1.190	1.201	.274
	Within Groups	239.806	242	.991		
	Total	240.996	243			
Too Much Ridicule	Between Groups	.036	1	.036	.043	.837
	Within Groups	204.630	241	.849		
	Total	204.667	242			
MI=More Tax Money	Between Groups	.081	1	.081	.095	.759
	Within Groups	208.001	243	.856		
	Total	208.082	244			
Need More Tolerance	Between Groups	2.279	1	2.279	2.862	<b>.092</b>
	Within Groups	194.294	244	.796		
	Total	196.573	245			
Minst=Prison	Between Groups	1.606	1	1.606	1.843	.176
	Within Groups	210.833	242	.871		
	Total	212.439	243			
Responsibility	Between Groups	2.174	1	2.174	2.577	.110
	Within Groups	205.859	244	.844		
	Total	208.033	245			
No sympathy	Between Groups	.067	1	.067	.103	.749
	Within Groups	158.325	243	.652		
	Total	158.392	244			
MI= Burden	Between Groups	.531	1	.531	.688	.408
	Within Groups	187.575	243	.772		
	Total	188.106	244			

Waste of Tax Money	Between Groups	.018	1	.018	.019	.890
	Within Groups	224.519	242	.928		
	Total	224.537	243			
Enough Services	Between Groups	3.437	1	3.437	4.954	.027
	Within Groups	168.588	243	.694		
	Total	172.024	244			
Avoid MI	Between Groups	.115	1	.115	.220	.639
	Within Groups	127.678	244	.523		
	Total	127.793	245			
No MI Responsibility	Between Groups	.827	1	.827	1.045	.308
	Within Groups	192.373	243	.792		
	Total	193.200	244			
Isolated	Between Groups	.042	1	.042	.073	.787
	Within Groups	139.024	242	.574		
	Total	139.066	243			
Marriage foolish	Between Groups	.073	1	.073	.097	.755
	Within Groups	181.780	243	.748		
	Total	181.853	244			
Not Neighbors	Between Groups	.028	1	.028	.028	.867
	Within Groups	238.739	242	.987		
	Total	238.766	243			
No Public Office	Between Groups	1.991	1	1.991	1.638	.202
	Within Groups	295.372	243	1.216		
	Total	297.363	244			
Keep Rights	Between Groups	.008	1	.008	.006	.939
	Within Groups	333.383	241	1.383		
	Total	333.391	242			

MI should have responsibility	Between Groups	3.403	1	3.403	3.825	<b>.052</b>
	Within Groups	217.117	244	.890		
	Total	220.520	245			
MI have neighborhood rights	Between Groups	2.217	1	2.217	2.419	.121
	Within Groups	222.738	243	.917		
	Total	224.955	244			
MI Less Dangerous	Between Groups	.593	1	.593	.735	.392
	Within Groups	196.757	244	.806		
	Total	197.350	245			
Women MI as Babysitters	Between Groups	1.685	1	1.685	2.266	.134
	Within Groups	179.987	242	.744		
	Total	181.672	243			
MIF should be accepted	Between Groups	5.700	1	5.700	8.713	<b>.003</b>
	Within Groups	159.617	244	.654		
	Total	165.317	245			
MI need community	Between Groups	2.192	1	2.192	3.130	<b>.078</b>
	Within Groups	170.200	243	.700		
	Total	172.392	244			
MIF should be community serviced	Between Groups	3.352	1	3.352	5.039	<b>.026</b>
	Within Groups	161.644	243	.665		
	Total	164.996	244			
MIF no threat	Between Groups	5.562	1	5.562	8.074	<b>.005</b>
	Within Groups	167.401	243	.689		
	Total	172.963	244			
Residents shouldn't fear MI	Between Groups	1.696	1	1.696	2.226	.137
	Within Groups	185.898	244	.762		
	Total	187.593	245			

MIF not in Res Nhoods	Between Groups	.933	1	.933	1.106	.294
	Within Groups	205.880	244	.844		
	Total	206.813	245			
Right to Resist	Between Groups	.502	1	.502	.668	.415
	Within Groups	183.530	244	.752		
	Total	184.033	245			
Risks to great for LMHI	Between Groups	.073	1	.073	.080	.777
	Within Groups	222.523	243	.916		
	Total	222.596	244			
MHI in RN is frightening	Between Groups	.797	1	.797	.952	.330
	Within Groups	203.594	243	.838		
	Total	204.392	244			
MHI downgrades NH	Between Groups	.916	1	.916	1.046	.307
	Within Groups	205.894	235	.876		
	Total	206.810	236			

**Table 1. S (Disease Relationship Categorization)  
ANOVA**

		Sum of Squares	df	Mean Square	F	Sig.
MI=Lack of Discipline	Between Groups	11.377	5	2.275	2.083	<b>.071</b>
	Within Groups	160.597	147	1.092		
	Total	171.974	152			
Control= Locked Doors	Between Groups	1.337	5	.267	.546	.741
	Within Groups	71.551	146	.490		
	Total	72.888	151			
MI are Distinguishable	Between Groups	3.651	5	.730	.719	.610
	Within Groups	146.322	144	1.016		
	Total	149.973	149			
Hospitalized	Between Groups	15.513	5	3.103	3.855	<b>.003</b>
	Within Groups	115.881	144	.805		
	Total	131.393	149			
MI Child=Supervision	Between Groups	1.007	5	.201	.235	.946
	Within Groups	118.965	139	.856		
	Total	119.972	144			
Normal Disease	Between Groups	.982	5	.196	.187	.967
	Within Groups	141.585	135	1.049		
	Total	142.567	140			
Not Outcasts	Between Groups	5.863	5	1.173	.946	.453
	Within Groups	179.634	145	1.239		
	Total	185.497	150			
Less Emphasis/Protection	Between Groups	15.406	5	3.081	4.124	<b>.002</b>
	Within Groups	109.094	146	.747		
	Total	124.500	151			

Mhospitals Outdated	Between Groups	12.025	5	2.405	2.921	<b>.015</b>
	Within Groups	119.405	145	.823		
	Total	131.430	150			
Anyone Can be MI	Between Groups	2.574	5	.515	.499	.777
	Within Groups	149.585	145	1.032		
	Total	152.159	150			
Too Much Ridicule	Between Groups	4.100	5	.820	.984	.430
	Within Groups	120.040	144	.834		
	Total	124.140	149			
MI=More Tax Money	Between Groups	2.276	5	.455	.529	.754
	Within Groups	125.698	146	.861		
	Total	127.974	151			
Need More Tolerance	Between Groups	3.877	5	.775	1.156	.334
	Within Groups	98.593	147	.671		
	Total	102.471	152			
Minst=Prison	Between Groups	5.426	5	1.085	1.343	.249
	Within Groups	117.117	145	.808		
	Total	122.543	150			
Responsibility	Between Groups	2.615	5	.523	.751	.587
	Within Groups	102.379	147	.696		
	Total	104.993	152			
No sympathy	Between Groups	3.207	5	.641	1.011	.414
	Within Groups	92.662	146	.635		
	Total	95.868	151			
MI= Burden	Between Groups	3.849	5	.770	1.044	.394
	Within Groups	108.387	147	.737		
	Total	112.235	152			

Waste of Tax Money	Between Groups	.935	5	.187	.193	.965
	Within Groups	142.372	147	.969		
	Total	143.307	152			
Enough Services	Between Groups	2.338	5	.468	.712	.615
	Within Groups	95.866	146	.657		
	Total	98.204	151			
Avoid MI	Between Groups	2.249	5	.450	.868	.504
	Within Groups	76.196	147	.518		
	Total	78.444	152			
No MI Responsibility	Between Groups	3.979	5	.796	1.042	.395
	Within Groups	112.231	147	.763		
	Total	116.209	152			
Isolated	Between Groups	.720	5	.144	.241	.944
	Within Groups	87.168	146	.597		
	Total	87.888	151			
Marriage foolish	Between Groups	5.345	5	1.069	1.524	.186
	Within Groups	103.126	147	.702		
	Total	108.471	152			
Not Neighbors	Between Groups	3.029	5	.606	.642	.668
	Within Groups	137.813	146	.944		
	Total	140.842	151			
No Public Office	Between Groups	8.219	5	1.644	1.534	.183
	Within Groups	156.459	146	1.072		
	Total	164.678	151			
Keep Rights	Between Groups	4.172	5	.834	.607	.695
	Within Groups	200.716	146	1.375		
	Total	204.888	151			

MI should have responsibility	Between Groups	5.724	5	1.145	1.376	.237
	Within Groups	122.328	147	.832		
	Total	128.052	152			
MI have neighborhood rights	Between Groups	2.831	5	.566	.694	.629
	Within Groups	119.143	146	.816		
	Total	121.974	151			
MI Less Dangerous	Between Groups	5.209	5	1.042	1.387	.233
	Within Groups	110.451	147	.751		
	Total	115.660	152			
Women MI as Babysitters	Between Groups	3.027	5	.605	.953	.449
	Within Groups	92.736	146	.635		
	Total	95.763	151			
MIF should be accepted	Between Groups	4.978	5	.996	2.067	<b>.073</b>
	Within Groups	70.800	147	.482		
	Total	75.778	152			
MI need community	Between Groups	5.866	5	1.173	1.832	.110
	Within Groups	93.503	146	.640		
	Total	99.368	151			
MIF should be community serviced	Between Groups	2.617	5	.523	.920	.470
	Within Groups	83.618	147	.569		
	Total	86.235	152			
MIF no threat	Between Groups	2.007	5	.401	.660	.654
	Within Groups	88.809	146	.608		
	Total	90.816	151			
Residents shouldn't fear MI	Between Groups	.365	5	.073	.111	.990
	Within Groups	97.021	147	.660		
	Total	97.386	152			

MIF not in Res Nhoods	Between Groups	1.638	5	.328	.469	.799
	Within Groups	102.597	147	.698		
	Total	104.235	152			
Right to Resist	Between Groups	1.245	5	.249	.399	.849
	Within Groups	91.814	147	.625		
	Total	93.059	152			
Risks to great for LMHI	Between Groups	3.229	5	.646	.922	.469
	Within Groups	103.006	147	.701		
	Total	106.235	152			
MHI in RN is frightening	Between Groups	4.896	5	.979	1.257	.286
	Within Groups	114.489	147	.779		
	Total	119.386	152			
MHI downgrades NH	Between Groups	3.631	5	.726	.893	.488
	Within Groups	117.892	145	.813		
	Total	121.523	150			