EXPERIENCE REQUIRED:
CONTACT WITH AND SOCIAL DISTANCE FROM THE MENTALLY ILL

THESIS

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CHAPTER 1

INTRODUCTION TO THE STUDY

The study reported here, in broad terms, can be viewed as an investigation of individual perceptions about persons with mental illness and the preferred social distance that results from those perceptions. More specifically, it focuses on the extent to which an individual is willing to interact with someone with a mental illness. The study looked at the extent to which persons with a mental illness were perceived as likely to be violent (to themselves or others). Additionally, the study examined the manner in which perceptions and preferred social distance might be influenced by prior social contact.

The study was based upon 601 responses to specific questions included in the Mental Health Module that was incorporated into the 1996 General Social Survey (GSS). As part of the survey, respondents were presented with certain vignettes, or descriptions of persons, and they were asked a series of questions concerning the person described in the vignette. The focus of this study was on the responses to two vignettes: one vignette described a person with major depression, and the other vignette described someone with schizophrenia.

Following a presentation of a specific vignette, each respondent was asked to indicate his or her preferred social distance from the person depicted in the vignette and to make a determination of the likelihood of violence on the part of the person depicted in the vignette. Additionally, each respondent was asked to indicate whether he or she knew anyone having been hospitalized because of a mental illness, and if so, what was his or her relationship to the person in question.

The Problem

> "Mental illness is a very threatening, fearful thing and not an idea to be entertained lightly about anyone. Emotionally, it represents to people a loss of what they consider to be the distinctively human qualities of rationality and free will, and there is kind of a horror in dehumanization. Mental illness is something that people want to keep as far from themselves as possible" (Star 1955:6).

Numerous investigations have focused on the general question of mental illness and social distance. For the most part, the studies represent attempts to determine what factors influence a person's preferred social distance from someone who is perceived as mentally ill. The studies can be thought of as falling into several broad categories. There are investigations into the role of stigma as it relates to social distance. There are studies that focus on possible links between perceived tendency toward violence and preferred social distance, as well as studies linking prior social contact and preferred social distance. There are also studies that examine demographic characteristics as

predictor variables of preferred social distance.

While the body of literature provides many clues as to why some people may be more tolerant than others when it comes to interactions with the mentally ill, this study attempts to focus on the extent to which someone's prior social contact with mentally ill persons may affect preferred social distance. The study involves a secondary analysis of data obtained from the General Social Survey (the GSS), a well-known, established social science database. More particularly, the survey used in this study is a revision of the groundbreaking work of Shirley Star's vignettes (Star 1955). Star's survey facilitates an assessment of the nature of public beliefs about mental illness, by describing hypothetical individuals who meet the criteria for various disorders and asking respondents questions about the individual, including the likelihood that the individual has a "mental illness." Star's research set the pace for future mental illness studies, both sociologically and psychologically.

Review of Literature

To begin the review of literature on mental illness, it is necessary first to clarify the key terms involved. How, for example, are the terms "preferred social distance," "perceived tendency toward violence," and "prior social contact" being used? First, the term "preferred social distance" is used to express the extent to which an individual is willing to interact with someone with a mental illness. Second, the term "perceived

tendency toward violence" is the belief that a person suffering from mental illness is likely to be violent to others or him or herself. Finally, the term "prior social contact" refers to the extent of an individual's previous experience with the mentally ill, presumably family, friends or acquaintances.

Furthermore, these three expressions are closely related to sociological language in terms of stigma, labeling theory, and symbolic interaction. Stigma is considered to be the negative perceptions and behaviors of so-called normal people to all individuals who are different from themselves (Page 1984:1, quoting R.W. English). In other words, individuals different from normal people are measured against a presumed standard, and are thereby discriminated against. In short, stigma directs social distance.

Labeling theory, as an explanation for deviance and, consequently, perceived violence, suggests that social groups make deviance by making rules whose infractions constitute deviance and by applying these rules to particular people and labeling them as outsiders (Becker 1963). When someone is labeled (identified as deviant), such as the mentally ill, it may lead to negative definitions (greater perceived likelihood of violence) from society.

Finally, symbolic interaction, as it relates to prior social contact with the mentally ill, suggests that because humans give meaning to their own behavior, they interpret subjective meanings of events, objects,

or behaviors. In other words, human beings create their environment through definition rather than simply responding to it. Thus, a focus on interaction (prior social contact) with the mentally ill and definition centers one's attention on the present situation as the cause of what society does (social distance preferences).

The Social Distance (Stigma) Link:

Not surprisingly, the matter of stigma has been a research topic when it comes to the question of preferred social distance from the mentally ill or, more specifically, the extent to which an individual is willing to interact with someone perceived to have a mental illness. In short, the assumption has been that the stigma associated with the status of mental illness would, in some way, produce the desire for greater preferred social distance from the mentally ill.

According to Goffman, (1963), stigma refers to a personal attribute that is deeply discrediting because it deviates from the norms of a social group. This personal attribute reduces him or her "in our minds from a whole and usual person to a tainted, discounted one." In other words, stigma results from possession of an attribute, such as the label of mental illness, that conveys a negatively valued social identity, which is socially constructed.

The stigma attached to individuals with mental illness may be as a result of a diagnostic label by doctors and thus an evaluative label by society. That is, how mentally-ill people are perceived by the public

depends in significant part on the label that is attached to the illness, which in turn predicts social distance.

There is a hierarchical arrangement of stigma, as suggested by Smart (2001), that persons who have physical disabilities have the least amount of stigma imposed on them; persons with cognitive disabilities have more stigma; and persons with intellectual disabilities have even more stigma directed toward them. It is those persons with psychiatric disabilities who experience the greatest amount of stigma. Intellectual functioning is considered the defining feature of humans, which suggests why individuals with intellectual disabilities would be stigmatized. This feature also explains why individuals with intellectual/mental disabilities have been portrayed for centuries by the media as dangerous and violent (Smart 2001:117-119).

The Perceived Tendency Toward Violence Link:

There are numerous studies linking perceived tendency toward violence and preferred social distance from the mentally ill. As might be expected, deviant perceptions of the mentally ill, in particular, a tendency toward violence, cause a preference for greater social distance from the mentally ill. In fact, recent research reports continued public desire for social distance from people with mental health problems because of widely-held perceptions of tendency toward violence that may play a role in the public's unwillingness to interact with people suffering from mental illness (Chung et al. 2001; Link et al. 1999; Martin et al.

2000; Phelan et al. 2000; Rosenberg and Attinson 1977; and Schnittker 2000).

> "One cornerstone of public attitudes is the feeling that the mentally ill are highly unpredictable and that the mentally ill are thought to be those people who do not go by the 'rules' and who, because of their erratic behavior, may suddenly embarrass or endanger others" (Rosenberg and Attinson 1977:80).

> "It (perceived dangerousness) points to the importance of the actual symptoms of disturbing behavior, the label of mental illness, and the influence of the public's perceptions of the potential danger of interacting with people suffering from mental illness" (Martin et al. 2000:211).

Star's 1955 research, in which she piloted the vignettes used in this study to examine attitudes of mental illness, found that public portrayals of mental illness were primarily derogatory, concluding that there was a strong tendency for people to associate mental illness with psychosis or violence and to view other kinds of behavioral or personality problems as "an emotional or character difference" (Star 1955).

Nunnally (1961), another pioneer in the study of public attitudes toward mental illness, found characteristics of a person labeled as "insane" or "neurotic" to a broad range of rejecting adjectives from "dangerous" and "bad" to "ignorant." His study on beliefs about mental illness examined 350 people from public and professional sources by using 240 statements relating to causes, symptoms, prognosis, incidence and social significance of mental health problems. Although he found that the public information about mental illness is not highly structured, he does contend that negative stereotypes of people with mental illnesses

abound in the media, which has sometimes portrayed mental patients as dangerous to others and implied that they can be unpredictably violent (p.46). Similarly, Scheff (1967), using media samples containing 111 hours of television transmission time, one week's total broadcasting time of four radio stations, 91 different magazines, 49 daily newspapers and confession magazines (which were more saturated with material relating to mental illness than any other source of media), examined the information that media specifically conveys about mental illness. He also contends that mass media are among the social forces that maintain this stereotype and incidentally portray mental illness in a misleading light (p.60).

The stereotypical depiction of mental illness as associated with violence indicates that it is the definitions of deviant behavior and the assignment of labels to such behavior that strongly influences attitudes toward those regarded as deviant (Rabkin 1972). In fact, labeling theory has emphasized the stereotyping, stigmatization, rejection, and exclusion of mentally ill people, who are also unsurprisingly defined as deviant. Scheff (1975) contends that when the labeling theory of deviance is applied to mental illness, it includes the following hypotheses: stereotyped imagery of mental disorders are learned in early childhood; and, the stereotypes of insanity are continually reaffirmed, inadvertently, in ordinary social interaction (p.10). For the present study, this suggests that humans operate on a social system of cultural stereotypes

which shapes behaviors, perception, thought, and feeling, and that this system acts through both positive and negative sanctions as well as through those imagined or assumed. The feelings that members of society have about its deviants are primarily collective emotions of fear and that persons who have never had contact with deviants have strong negative feelings.

Since labeling mental illness is primarily a social act, Rosenfield (1997), in her review of the literature on labeling mental illness, suggests that a psychiatric label, similar to a badge we pin on people, sets into action cultural stereotypes, negative images (perceived tendency toward violence) about mental illness and subsequently social distance from the mentally ill (p.660). However, Cormack and Furnham (1998) concluded that psychiatric labeling did not have a statistically significant main effect on social distance (p.241). Using a sample of 117 young adults, they examined the labeling of mental illness by asking respondents to complete an anonymous questionnaire, containing vignettes, which were based on those of Star's 1955 vignettes. We may explain Cormack and Furnham's different findings by the survey used in their study. That is, the type of behavior portrayed in the vignettes was more influential than the actual label of the person depicted in the vignette, which may have had a statistically significant effect on social distance.

Arguably, an evaluative label may be what ultimately sets the stage for stigmatizing and negative attitudes toward the mentally ill. Because

society's expectations are attached to the label of deviance, which, in turn, perpetuates the mental illness, it makes it difficult to ignore the labeling of mental illness as a precursor and/or predictor of social distance preferences from the mentally ill. However, Scheff 's (1975) hypotheses of stereotyped imagery of mental disorders being learned in early childhood and stereotypes of insanity being continually reaffirmed, inadvertently, in ordinary social interaction evokes the notion that prior social contact with the mentally ill is another predictor of preferred social distance from the mentally ill. In fact, Scheff's (1984) experiences with the administrative staffs of mental hospitals suggests that persons who have never had contact with deviants have strong negative feelings, sometimes stronger than persons in contact with deviants (p.200).

The Prior Social Contact Link:

For the most part, sociological research has examined mental illness from a labeling perspective in forms of stigma and deviance. However, symbolic interaction may be the more direct theoretical perspective for this study, concerning prior social contact and preferred social distance from the mentally ill. More specifically, since symbolic interaction is shaped and modified by interaction, this directs our attention to prior social contact.

Symbolic interaction is a sociological perspective that emphasizes the meanings that humans give to their behavior. That is, because humans have the capacity for self-reflection, they give meaning to their

own behavior, and this is how they interpret subjective meanings of different events, objects, or behaviors. According to this theory, people behave based on what they believe, not on what may be objectively true; thus, society is considered to be socially constructed through human interpretation, existing in the minds of people, and having effects that are real (Anderson and Taylor 2001:19, quoting Berger and Luckmann 1967 and Blumer 1969). In other words, Anderson and Taylor (2001) suggest that people interpret each other's behavior, and it is these interpretations that create social meaning and form social bonds; that social order, then, is seen as constantly being negotiated and created through the interpretations people give to their behavior (p.19).

Because symbolic interaction understands humans through interpretations of interactions rather than through personality or the impact of the larger society, the act of interpreting interactions is what then creates and sustains one's experience, one's reality. Theoretically, individuals who have prior social contact with the mentally ill, will define the mentally ill as less dangerous or violent than those having no contact since the mentally ill are, in fact, rarely dangerous or violent. Thus, expected preferred social distance will be a direct result of level of contact with the mentally ill. For example, the stereotyped image of the mentally ill, as dangerous or violent, which Scheff (1975) says is learned in childhood, can be seen as interpretations of interactions, which were the viewpoints of significant others, such as a child's parent. These parental

viewpoints are what the child uses to make sense of his or her world, his or her experience -- or lack of -- with the mentally ill. That is, the constructed reality of mental illness, being defined or labeled as deviant or dangerous, means to fear the mentally ill. Therefore, it can be argued that close interaction with the mentally ill should reduce or eliminate the fears held about the mentally ill and, in turn, lessen one's preferred social distance from the mentally ill.

Although there have been recent studies (Chung et al. 2001; Link et al. 1999; Phelan et al. 2000; and Read and Law 1999) focusing on the effects of contact with the mentally ill with regard to perceived dangerousness and social distance, the studies have been few, and not generalizable, with some falling short in that they did not involve random samples. Despite this shortcoming, the findings do suggest that individuals having had no previous contact with the mentally ill perceive the mentally ill as dangerous and therefore maintain a greater social distance from them. On the other hand, findings also suggest that people having a better understanding of mental illness are more willing to make personal contact with the mentally ill, and that contact with the mentally ill does lead to more favorable attitudes toward the mentally ill (Chung et al. 2001; Link et al. 1999; Phelan et al. 2000; and Read and Law 1999).

The Demographic Link:

Numerous studies have suggested a link between certain

demographic characteristics and preferred social distance from the mentally ill. In particular, studies on mental illness have focused on demographic characteristics such as age, education, gender, and religion.

Previous research suggests that age and education are related to attitudes toward the mentally ill. In particular, Crocetti, Spiro, and Siassi (1974), using a sample of 1,738 participants, examined the relationship between age and educational attainment of respondent and attitudes toward mental illness by asking respondents to complete an anonymous questionnaire based on Star's 1955 vignettes. Their study concluded that the younger and more educated the respondent, the more positive their attitudes toward mental illness (p.46). That is, age and educational attainment (knowledge) are influential factors in the ability to recognize mental illness. Martin et al. (2000), in their review of the literature, suggest that these positive attitudes toward the mentally ill are due to an "increased sophistication regarding the nature and causes of mental health problems together with the replacement of older, more prejudiced cohorts with younger, more liberal cohorts." In other words, younger and more educated people are having lower levels of prejudice and more tolerance toward the mentally ill and are, likewise, replacing older, more prejudiced people.

Similarly, Wolff, Pathare, Craig, and Leff (1996), using an interview survey of 215 residents in two English communities, examined the

relationship between negative attitudes toward the mentally ill and lack of knowledge which was hypothesized to exacerbate such negative attitudes. They concluded that respondents with less knowledge about mental illness exhibited a greater degree of socially controlling attitudes, especially those who are age 50+, of lower social class, and/or of non-Caucasian ethnic origin. In other words, they found that negative attitudes toward the mentally ill are predominantly fueled by lack of knowledge.

On the other hand, Chou, Mak, Chung, and Ho (1996) found that there is no relationship between level of education and knowledge of mental illness. Their study of 1,751 respondents examined the perceived mental illness and social distance by gathering a random sampling from a 1994 telephone directory and using a structured questionnaire for telephone interviewing. They concluded that knowledge of cognitive mental illness is not a major determinant of public attitude toward mental patients; however, "it seems that knowledge of mental illness alone does not guarantee the acceptance of mental patients as neighbors" (p.217). Likewise, Martin et al. (2000), in their GSS-based study using a sample of 1,444 randomly selected respondents, concurred in their findings that schooling, among other demographic variables, does not appear to be an important correlate of social distance attitudes toward the mentally ill.

With regard to gender and mental illness, research offers mixed findings. Norman and Malla (1983) found that male and female respondents do not differ significantly in their perceptions toward mental illness. However, Cormack and Furnham (1998) found that female subjects anticipated a more pessimistic prognosis of mental illness than male subjects. Their study examined labeling and sex role stereotypes of mental illness by using a small but convenient sample of 117 teenage and young adults. Again, basing their questionnaire on Star's vignettes, with only minor word changes, females were found not only to have more negative prediction of mental illness than men, they also judged the portrayed behavioral deviance to be more serious than did male subjects (p.241).

On the other hand, Ng and Chan (2000) found that females scored higher regarding compassion, while males were found to have more stereotyping, restrictive, pessimistic and stigmatizing attitudes toward mental illness. Their conclusions were found by using a sample of 2,223 teenagers to examine the relationship between sex differences and attitudes toward mental illness and by asking respondents to complete a self-administered questionnaire. For the most part, the finding suggests that women hold more positive attitudes toward mental illness than do men. Similarly, Schnittker (2000), using the 1996 GSS mental health module to sample 1,302 respondents, examined the influence of gender and public reactions to psychological problems with an emphasis on

social tolerance and perceived dangerousness. He concluded that respondents of either gender claim greater willingness to interact socially with female characters than with male characters portrayed with the same psychological problems, possibly because female characters are rated as less dangerous to others (p.1101).

Since religion is a central element in culture, there is a great likelihood that religion and religious beliefs influence perceived mental illness. Ellision, Boardman, Williams, and Jackson (2001), using a sample of adult respondents from the 1995 Detroit Area Study (DAS), examined the relationship between religion and mental health. They concluded that involvement in religious practices, such as prayer and involvement in church social activities, and religious beliefs influence individuals' perceived well-being. Not only does religion provide form and direction to human thought, feeling, and action, it also stabilizes human orientations and values.

It has also been suggested that those from a theologically conservative Christian group might generally have more negative attitudes towards those with mental health problems because of the association of mental illness with personal sin and demon possession. However, one study, using a sample consisting of 68 members from a predominantly white, middle class, evangelical congregation, examined the relationship between a church congregation and attitudes of the public to mental health by asking respondents to complete a

questionnaire. The study found that the church group expressed less negative and rejecting attitudes to people with mental illness than the compared general population, that there was no evidence of judgmental attitudes toward those with mental illness, but that the church group did have major concerns about violent tendencies from the mentally ill (Gray 2001:71).

Summary

Even though researchers (Chung, Chen, and Liu 2001; Huxley 1993; Link, Phelan, Bresnahan, Stueve, and Pescosolido 1999; Martin, Pescosolido, and Tuch 2000; Phelan, Link, Stueve, and Pescosolido 2000; and Read and Law 1999) suggest there has been an increase in the public's knowledge about mental illness, stigma remains pervasive. Hannigan (1999), while studying labeling theory and particularly Scheff's sociological theory of mental illness, suggests that among at least a minority of members of the public, overwhelmingly negative and stigmatizing attitudes were held toward people with mental health needs, their care in community setting, and their participation in social life (p.437). In short, society, no matter how sophisticated, continues to pin the badge of unacceptable human qualities on people with mental illness.

Clearly, the attitudes society has toward the mentally ill affect desire for social distance from the mentally ill; but whether prior interaction with the mentally ill determines social distance preference is

largely unexamined. Thus, the question remains: Does the level of prior social contact influence preferred social distance from the mentally ill? The study reported here aimed to examine the association between prior social contact and preferences for social distance from the mentally ill.

Research Hypotheses

Based on the previous research, the study reported here attempted to determine what factors influence preferred social distance (the extent to which an individual is willing to interact with someone with a mental illness) from the mentally ill. More particularly, the focus was to explore the association between prior social contact (an individual's personal or impersonal experience with the mentally ill) with the mentally ill, as well as perceived tendency toward violence (the belief that a person with mental illness is likely to be violent to others or themselves), with levels of preferred social distance from the mentally ill. It was hypothesized that experience with the mentally ill, as well as perceptions of the mentally ill, are important factors in preferences for social distance from the mentally ill.

The reader will remember that studies (Chung et al. 2001; Link et al. 1999; Phelan et al. 2000; and Read and Law 1999) suggest that individuals having no previous contact with the mentally ill perceive the mentally ill as dangerous and therefore maintain a greater social distance from them. The same studies also suggest that people having a

better understanding of mental illness are more willing to make personal contact with the mentally ill, and that contact with the mentally ill does lead to more favorable attitudes toward the mentally ill. Therefore, the hypotheses were as follows:

- There is an inverse association between level of prior social contact and level of perceived tendency toward violence.
- There is an inverse association between level of prior social contact and level of preferred social distance.

The reader will also remember that recent research (Chung et al. 2001; Link et al. 1999; Martin et al. 2000; Phelan et al. 2000; and Schnittker 2000) has reported continued public desire for social distance from people with mental health problems, suggesting that widely held perceptions of violence may play a role in the public's unwillingness to interact with people with mental illness. Therefore, the research hypothesis was as follows:

- There is a direct association between level of perceived tendency toward violence and level of preferred social distance.

Taken together and expressed in null format, the various hypotheses were as follows:

- There is no difference between level of prior social contact and level of perceived tendency toward violence.
- There is no difference between level of prior social contact and level of preferred social distance.
- There is no difference between level of perceived tendency toward violence and level of preferred social distance.

CHAPTER 2

METHODOLOGY

Overview

The present study was based upon a data set that included the responses of 601 participants to the 1996 General Social Survey (GSS). More specifically, each of the 601 participants was presented with one or the other of two vignettes during the survey process. Following a presentation of the vignette, respondents were asked a series of questions about their reactions to or attitudes toward the person described in the vignette.

Each vignette was constructed so as to describe or emphasize symptoms associated with a major mental illness. One vignette described behaviors associated with a diagnosis of major depression. The other vignette behaviors associated with a diagnosis of schizophrenia. Each respondent was randomly assigned to read one vignette, whose subjects were randomly varied by sex, education level (eighth grade, high school, college), and ethnicity (White, African American, Hispanic) of the person described in the vignette. A name was also randomly assigned to each vignette subject (John, Juan, Mary,

Maria). The vignette based on the *major depression* scenario was as follows:

> (John/Juan/Mary/Maria) is a (white/African American/Hispanic) (man/woman) with an (eight grade/high school/college) education. For the past two weeks, (John/Juan/Mary/Maria) has been feeling really down. He/She wakes up in the morning with a flat heavy feeling that sticks with him/her all day long. He/She isn't enjoying things the way he/she normally would. In fact nothing gives him/her pleasure. Even when good things happen, they don't seem to make (John/Juan/Mary/Maria) happy. He/She pushes on through his/her days, but it is really hard. The smallest tasks are difficult to accomplish. He/She finds it hard to concentrate on anything. He/She feels out of energy and out of steam. And even though (John/Juan/Mary/Maria) feels tired, when night comes he/she can't go to sleep. (John/Juan/Mary/Maria) feels pretty worthless, and very discouraged. (John's/Juan's/Mary's/Maria's) family has noticed that he/she hasn't been himself/herself for about the last month and that he/she has pulled away from them. (John/Juan/Mary/Maria) just doesn't feel like talking.

The vignette based on the *schizophrenia* scenario was as follows:

> (John/Juan/Mary/Maria) is a (white/African American/Hispanic) (man/woman) with an (eight grade/high school/college) education. Up until a year ago, life was pretty okay for (John/Juan/Mary/Maria). But then, things started to change. He/She thought that people around him/her were making disapproving comments, and talking behind his/her back. (John/Juan/Mary/Maria) was convinced that people were spying on him/her and that they could hear what he/she was thinking. (John/Juan/Mary/Maria) lost his/her drive to participate in his/her usual work and family activities and retreated to his/her home, eventually spending most of his/her day in his/her room. (John/Juan/Mary/Maria) was hearing voices even though no one else was around. These voices told him/her what to do and what to think. He/She has been living this way for six months.

The questions that followed the presentation of the vignettes were numerous and wide-ranging in scope. Those questions relevant to the present study, however, were found in three subject areas: Questions concerning social distance; questions concerning tendencies toward violence; and questions concerning prior social contact with the mentally ill in general. Specific questions and response possibilities as they were presented to the participants are outlined below.

Measurement of the Major Variables

The Preferred Social Distance Variable:

As noted previously, preferred social distance was defined as follows: The extent to which a person is willing to interact with another person. In the present instance, preferred social distance actually reflects the extent to which the respondent would be willing to interact with the individual described in the vignette.

Respondents were presented with a variety of questions on the matter of preferred social distance. More specifically, each respondent was asked to respond to each of the following:

- How willing would you be to move next door to (name of the person depicted in the vignette)?
- How willing would you be to spend an evening socializing with (name of the person depicted in the vignette)?
- How willing would you be to make friends with (name of the person depicted in the vignette)?

- How willing would you be to have (name of the person depicted in the vignette) start working closely with you on a job?

- How willing would you be to have a group home for people like (name of the person depicted in the vignette) opened in your neighborhood?

- How willing would you be to have (name of the person depicted in the vignette) marry into your family?

In each instance, the respondent was given the following response options: Willing; probably willing; probably unwilling; and definitely unwilling. Scores for the responses were assigned along a scale of willingness from one to four (with a score of one representing "willing" and a score of four representing "definitely unwilling").

To determine the degree of social distance from the mentally ill person depicted in the vignette, responses to the social distance questions were recoded as follows: (0) Willing, which included definitely willing and probably willing; and (1) Not Willing, which included probably unwilling and definitely unwilling. In order to create a social distance score, a new variable was computed by summing the responses, so that the scores ranged from 0 (low social distance) to 6 (high social distance).

The Perceived Tendency Toward Violence Variable:

As noted previously, perception of tendency toward violence was defined as follows: the belief that persons with mental illness is likely to be violent to others or themselves.

Respondents were presented with two questions regarding violence on the part of the person depicted in the vignette. Specifically, each respondent was asked to respond to each of the following:

- In your opinion, how likely is it (name of the person depicted in the vignette) would do something violent toward other people?
- In your opinion, how likely is it (name of the person depicted in the vignette) would do something violent toward him or herself?

In each instance, the respondent was given the following response options: Very likely; somewhat likely; not very likely; not likely at all. Scores for the responses were assigned along a scale of violence from one to four (with a score of one representing "very likely" and a score of four representing "not likely at all").

In this analysis, to determine perceived tendency toward violence on the part of the mentally ill person depicted in the vignette, responses were recoded by combining and dichotomizing the data as follows: (1) Likely, which included very likely and somewhat likely; and (2) Not Likely, which included not very likely and not likely at all.

The Prior Social Contact Variable:

As noted previously, prior social contact was defined as follows: The extent to which an individual has had previous personal or impersonal experience with the mentally ill in general.

Independent of the depicted vignettes, respondents were presented with a question, regarding prior social contact with the mentally ill. In

other words, participants were not responding to the vignettes depicting someone with major depression or schizophrenia. In particular, respondents were asked if they ever knew anyone who was in a hospital because of mental illness, and if so, what relation was that person to the respondent. If the respondent answered "yes" to the first question, only then did the other question follow. Specifically, each respondent was asked to respond to one or both of the following:

- Did you ever know anyone who was in a hospital because of a mental illness?
- Was this a relative, a close friend, or just someone you didn't know very well?

In the instance regarding the first question, the respondent was given the following response options: yes or no. If the respondent answered "yes," the respondent was then asked whether the patient they knew was either the respondent him or herself, immediate family, other relative, close friend, or acquaintance. Response options were as follows: self; not self; immediate family; not immediate family; other relative; not other relative; close friend; not close friend; and acquaintance; not acquaintance. Scores for each response were assigned a one or a two (with a score of one representing "self," "immediate family," "other relative," "close friend," and "acquaintance" and a score of two representing "not self," "not immediate family," "not other relative," "not close friend," and "not acquaintance").

In order to create a level of contact measure for this study, the data were categorized and recoded as follows: (1) Close Prior Social Contact, which included contact with the respondent, immediate family, or close friends; and (2) Casual Prior Social Contact, which included contact with other relatives, or acquaintances.

CHAPTER 3

FINDINGS

Characteristics of the Sample

The GSS sample that served as the basis for this study was limited to the 1996 Mental Health Module (n=601). This data set included those responding to the major depression vignette (n=300) and those responding to the schizophrenia vignette (n=301).

Demographics (Table1)

The mean age of the participants responding to the major depression vignette was 43.34, and the mean age of the participants responding to the schizophrenia vignette was 45.28. The majority of participants (major depression 79%; schizophrenia 85.4%) reported Anglo American as their ethnicity. When reporting marital status, slightly over half (major depression 50.7%; schizophrenia 55.8%) were married. The majority of the respondents (major depression 66.4%; schizophrenia 62.5%) had a high school education. When reporting average total family income, participants (major depression 65.4%; schizophrenia 62.5%) reported $25,000 or more. Finally, when reporting

the religion in which the participant was raised, over half of the participants (major depression 64.7%; schizophrenia 58.1%) reported Protestant.

Characteristics on Prior Social Contact (Table 1)

The reader will remember that participants were presented with a question regarding prior social contact with the mentally ill in general, and that the participants were not responding to the vignette depicting someone with major depression or schizophrenia. However, the two groups are relatively similar in terms of prior social contact with the mentally ill in general. Participants being given the major depression vignette, 97.1% reported having had close prior social contact with someone having been hospitalized because of a mental illness. Similarly, 91.5 percent of the participants being given the schizophrenia vignette reported having had close prior social contact with someone having been hospitalized because of a mental illness. Regarding the relationship with the mentally ill person with whom they had contact, 57.4 percent of the participants being given the major depression vignette and 53.5 percent of the participants being given the schizophrenia vignette reported the mentally ill person with whom they had contact to be someone within the respondent's family.

Characteristics on Perceived Tendency Toward Violence (Table 1)

In terms of perceived tendency toward violence on the part of the

mentally ill person described in the major depression vignette, 66.7 percent of the participants reported it not likely that the person depicted in the vignette would be violent toward others; however, 74.9 percent indicated that the person would likely be violent toward him or herself.

Regarding perceived tendency toward violence on the part of the mentally ill person described in the schizophrenia vignette, 60.9 percent of the participants reported it likely that the person depicted in the vignette would be violent toward others, with 86.5 percent of the participants also reporting it likely that the person would be violent toward him or herself.

Characteristics on Preferred Social Distance (Table 1)

Finally, in terms of the social distance scale, the reader will remember that in order to determine the degree of social distance from the mentally ill person depicted in the vignettes, responses to the social distance questions were recoded to create a social distance scale ranging from 0 (low social distance) to 6 (high social distance). The mean score was 2.25 for participants responding to the major depression vignette and 2.86 for participants responding to the schizophrenia vignette.

Hypotheses developed for this study used a total score to measure preferred social distance from the mentally ill. In addition, tests were run on social distance variables on a question-by-question basis. Frequency distributions were run for the six individual social distance questions pertaining to the willingness to associate with the person

depicted in the major depression and schizophrenia vignettes. Most participants reported they were willing to have the described major depressive or schizophrenic as a neighbor, socialize with that person, have a friendship with that person, and have a group home for people like that person in their neighborhood, but acceptance of persons depicted in the vignettes was not universal. For instance, in terms of schizophrenia, 63.1 percent of the participants reported they were not willing to work closely with that person on a job. There was also a significant lack of willingness to have that person marry into their family (for major depression (60.6%), as well as schizophrenia (72.2%)).

To further analyze the individual social distance questions, demographic characteristics (gender, race, country of origin, and education, among other demographic variables) were tested using Pearson Chi-Square; however, only four specific variables were found to be significant ($p<.05$). With reference to gender, females (82.8%) were more willing to have a friendship with the person depicted with major depression than were males (70.1%). Females (74.7%) were also more willing to have a group home in their neighborhood for the person depicted with major depression than were males (62.1%). Pertaining to race, Anglo-Americans (63.7%) were more willing than African Americans (40.7%) to have a schizophrenic neighbor. Regarding the respondent's country of origin, Europeans (81.9%) were more willing to have a friendship with the person having major depression than any other

ethnicity. Participants, having less than a college education (70.6%), reported more willingness to have a group home in their neighborhood for people like the person with schizophrenia than respondents with a college education (58.2%).

Additional analyses were performed on the individual social distance questions and the prior social contact variable, revealing significant associations ($p<.05$) using Pearson Chi-Square. The reader will remember that participants were presented with a question, regarding prior social contact with the mentally ill in general but were not responding to the vignettes depicting someone with major depression or schizophrenia. When questioned about prior social contact, particularly *"Did you ever know anyone who was in a hospital because of a mental illness?"*, a significant association was found regarding the respondents' willingness to have a group home in their neighborhood for people similar to the person depicted in the vignette. In particular, 67.2 percent of the respondents, who had close prior social contact with someone having major depression, were willing to have a group home in their neighborhood for people with major depression.

Although the following associations are not statistically significant, they are related to the interest of this study. While close prior social contact is a factor for social distance in this study, a reflection of positive attitude (social distance) is not always the case. Respondents having close prior social contact with someone having major depression reported

a willingness to associate with the person depicted in the major depression vignette on all but one social distance question. When asked, "How willing would you be to have 'the person' marry into your family?", respondents were not willing to have that person marry into their family even when they had close prior social contact with someone like that person depicted in the major depression vignette. For respondents who were read the schizophrenia vignette, their responses follow those for major depression; however, when asked, "How willing would you be to have 'the person' start working closely with you on a job?", respondents were not willing to work closely with that person even when they had close prior social contact with someone having schizophrenia.

Again, using Pearson Chi-Square, significant associations ($p<.05$) between the individual social distance questions and variables on violence were found. When asked the question, *"How likely is it 'the person' would do something violent toward other people?"*, 69.7 percent of the participants, who reported "not likely" that the person depicted in the major depression vignette would be violent toward others, were willing to socialize with that person and 82 percent were also willing to have a friendship with that person. However, 73.9 percent of the participants, who reported it "likely", were not willing to have that person marry into their family. Participants reporting it "likely" that the person with schizophrenia would be violent toward others were not willing to work

closely with that person (71.1%) nor have that person marry into their family (78.1%). However, those reporting it "not likely" that the person depicted in the schizophrenia vignette would be violent toward others were willing to have that person as a neighbor (80%), to socialize with that person (63.6%), to have a friendship with that person (83.8%), and to have a group home for people like that person in their neighborhood (76.5%).

When asked the question, *"How likely is it 'the person' would be violent toward him or herself?"*, 74.3 percent of the participants, who reported it "not likely" that the person depicted in the major depression vignette would be violent toward him or herself, were willing to socialize with that person; but 64.1 percent of the participants, who reported it "likely" were not willing to have that person marry into their family. For schizophrenia, 77.8 percent of the participants reporting it "not likely" that the person depicted in the vignette would be violent toward him or herself were willing to have that person as their neighbor; but 64.6 percent who reported it "likely" were not willing to work closely with that person.

Tests of Hypotheses

Separate analyses were conducted on the two groups (major depression and schizophrenia); and for the most part, the findings were similar across the board. To test the hypotheses, Pearson Chi-Square

and t-test were used to determine what relationships exist between the variables of interest.

Major Depression: Hypothesis 1 (Table 2)

Hypothesis 1 predicted that there is an inverse association between level of prior social contact and level of perceived tendency toward violence on the part of the mentally ill. That is, as the level of prior social contact increases, the level of perceived tendency toward violence decreases. It was anticipated that those who had close prior contact would have lower levels of perceived tendency toward violence by the mentally ill. To test the hypothesis, a t-test was performed to compare the mean level of perceived tendency toward violence on the basis of two groups: those who had close prior contact and those who had casual prior contact with the mentally ill in general. There were no significant findings between prior social contact and perceived tendency toward violence on the part of the mentally ill (the person depicted in the major depression vignette). Hypothesis 1 is not supported.

The null hypothesis stated there is no difference between level of prior social contact and level of perceived tendency toward violence on the part of the mentally ill. A Pearson Chi-Square was used to test the hypothesis, and no significant association was found. Therefore, failure to reject the null is warranted.

Major Depression: Hypothesis 2 (Table 3)

Hypothesis 2 predicted an inverse association between level of prior social contact and level of preferred social distance from the mentally ill. That is, as the level of prior social contact increases, the level of preferred social distance decreases. To test the hypothesis, a t-test was performed to compare the mean social distance scores on the basis of two groups: those who had close prior contact and those who had casual prior contact with the mentally ill. The reader will remember that participants were presented with a question, regarding prior social contact with the mentally ill in general, and that the participants were not responding to the vignette depicting someone with major depression. Respondents who had close prior social contact with someone who had been hospitalized because of a mental illness reported lower scores on the social distance scale than did those having casual prior social contact. The mean social distance score for close prior social contact was 2.27, and the mean social distance score for casual prior social contact was 3.50. The difference between the means is not statistically significant; therefore, Hypothesis 2 is not supported.

The null hypothesis stated there is no difference between level of prior social contact and level of preferred social distance from the mentally ill. A Pearson Chi-Square was used to test the hypothesis, and no significant association was found. Therefore, failure to reject the null is warranted.

Major Depression: Hypothesis 3 (Tables 4 and 6)

Hypothesis 3 predicted that there is a direct association between level of perceived tendency toward violence and preferred social distance from the mentally ill. That is, the higher the perceived tendency toward violence on the part of the mentally ill, the higher the level of preferred social distance from the mentally ill. Results for Hypothesis 3 were not surprising since past research suggest there is a relationship between attitudes of the mentally ill and perceived tendency toward violence.

When asked the question, "In your opinion, how likely is it that (name of the person depicted in the major depression vignette) would do something violent toward other people," a statistically significant association ($p<.05$) was found between perceived tendency toward violence and preferred social distance, using Pearson Chi-Square. Respondents (60%), who had a total social distance score of 6 from the person depicted in the major depression vignette, reported it likely that the person would be violent toward others. However, 84.5 percent of the respondents who had a total social distance score of 0 from the person depicted in the major depression vignette, reported it not likely that the person would be violent toward others.

Results from t-tests, comparing the mean social distance with perceived tendency toward violence on the part of the mentally ill, namely the person depicted in the major depression vignette, also found a statistically significant association. The mean social distance score for

participants who responded that the person depicted in the major depression vignette would likely be violent toward others was 2.77, and the mean social distance score for participants who responded that the person depicted in the vignette would not be violent toward others was 1.92. The difference between the means is statistically significant ($p<.01$). More specifically, participants reporting "not likely" that the person depicted in the major depression vignette would be violent toward others prefer less social distance from that person than participants reporting "likely" that the person depicted in the vignette would be violent toward others.

When asked the question, "In your opinion, how likely is it that (name of the person depicted in the major depression vignette) would do something violent toward him or herself," no significant findings were found using either Pearson Chi-Square or t-test analyses. However, participants who reported it likely that the person depicted in the major depression vignette would do something violent toward him or herself prefer greater social distance. Their responses were similar to participants who reported violence not likely.

Regardless of the above question, with regard to perceived tendency toward violence toward him or herself, Hypothesis 3 is warranted, and the null is rejected.

Schizophrenia: Hypothesis 1 (Table 2)

Hypothesis 1 predicted that there is an inverse association between

level of prior social contact and level of perceived tendency toward violence on the part of the mentally ill. That is, as the level of prior social contact increases, the level of perceived tendency toward violence decreases. It was anticipated that those who had close prior contact would have lower levels of perceived tendency toward violence by the mentally ill. To test the hypothesis, a t-test was performed to compare the mean level of perceived tendency toward violence on the basis of two groups: those who had close prior contact and those who had casual prior contact with the mentally ill in general. There were no significant findings between prior social contact and perceived tendency toward violence on the part of the mentally ill (the person depicted in the schizophrenia vignette). Hypothesis 1 is not supported.

The null hypothesis stated there is no difference between level of prior social contact and level of perceived tendency toward violence on the part of the mentally ill. A Pearson Chi-Square was used to test the hypothesis, and no significant association was found. Therefore, failure to reject the null is warranted.

Schizophrenia: Hypothesis 2 (Table 3)

Hypothesis 2 predicted an inverse association between level of prior social contact and level of preferred social distance from the mentally ill. To test the hypothesis, a t-test was performed to compare the mean social distance scores on the basis of two groups: those who had close prior contact and those who had casual prior contact with the

mentally ill. The reader will remember that participants were presented with a question, regarding prior social contact with the mentally ill in general, and that the participants were not responding to the vignette depicting someone with schizophrenia. Respondents who had close prior social contact with someone who had been hospitalized because of a mental illness reported lower scores on the social distance scale than did those having casual prior social contact. The mean social distance score for close prior social contact was 2.46, and the mean social distance score for casual prior social contact was 2.0. The difference between the means is not statistically significant; therefore Hypothesis 2 is not supported.

The null hypothesis stated there is no difference between level of prior social contact and level of preferred social distance from the mentally ill. A Pearson Chi-Square was used to test the hypothesis, and no significant association was found. Therefore, failure to reject the null is warranted.

Schizophrenia: Hypothesis 3 (Tables 5 and 6)

Hypothesis 3 predicted that there is a direct association between level of perceived tendency toward violence and preferred social distance from the mentally ill. That is, the higher the perceived tendency toward violence on the part of the mentally ill, the higher the level of preferred social distance from the mentally ill. Results for Hypothesis 3 were not surprising since past research suggest there is a relationship between

attitudes of the mentally ill and perceived tendency toward violence.

When asked the question, "In your opinion, how likely is it that (name of the person depicted in the schizophrenia vignette) would do something violent toward other people," a statistically significant association ($p<.01$) was found between perceived tendency toward violence and preferred social distance, using Pearson Chi-Square. Respondents (92.3%), who had a total social distance score of 6 from the person depicted in the schizophrenia vignette reported it likely that the person would be violent toward others. However, 66.7 percent of the participants who had a total social distance score of 0 from the person depicted in the schizophrenia vignette, reported it not likely that the person would be violent toward others.

Results from t-tests, comparing the mean social distance with perceived tendency toward violence on the part of the mentally ill, namely the person depicted in the schizophrenia vignette, also found a statistically significant association. The mean social distance score for participants who responded that the person depicted in the schizophrenia vignette would likely be violent toward others was 3.37, and the mean social distance score for participants who responded that the person depicted in the vignette would not be violent toward others was 1.93. The difference between the means is statistically significant ($p<.01$). More specifically, participants reporting "not likely" that the person depicted in the schizophrenia vignette would be violent toward

others prefer less social distance from that person than participants reporting "likely" that the person depicted in the vignette would be violent toward others.

When asked the question, "In your opinion, how likely is it that (name of the person depicted in the schizophrenia vignette) would do something violent toward him or herself," no significant findings were found using either Pearson Chi-Square or t-test analyses. However, participants who reported it likely that the person depicted in the schizophrenia vignette would do something violent toward him or herself prefer greater social distance. Their responses were similar to participants who reported violence not likely.

Regardless, of the above question, with regard to perceived tendency toward violence toward him or herself, Hypothesis 3 is warranted, and the null is rejected.

Additional Findings

The GSS Mental Health module included six individual questions on willingness to associate with the person depicted in both the major depression and schizophrenia vignettes, and a social distance score was developed from these questions. The same module also included other questions (pathologic parameters) about the person depicted in the vignette, such as: "How serious would you consider the problem to be?"; "How likely is it that the situation might be caused by 'his or her own

bad character,' or 'a chemical imbalance,' or 'the way he or she was raised,' or 'stressful circumstances in his or her life,' or 'genetics,' or 'God's will?'"; and "How likely is it that the person depicted in the vignette is experiencing 'the normal ups and downs of life,' 'a nervous breakdown,' 'a mental illness,' 'a physical illness,' and the '(specific label of the vignette version read to the respondent)?'".

In the course of analyzing the data, statistically significant results were discovered in a variety of areas. In particular, significant associations between the six individual questions on willingness to associate with the person depicted in the major depression or schizophrenia vignette between various pathologic control variables were found using Pearson Chi-Square.

Pathologic Parameters:

In analyzing the additional questions from the GSS, together with the individual social distance questions, significant associations ($p<.05$) were found, using Pearson Chi-Square. The specific questions included: whether that person's problem is caused by his or her own bad character, a chemical imbalance, genetics, and God's will; and whether that person is experiencing the normal ups and downs of life, a nervous breakdown, a mental illness, and the specific label of the vignette version read to the respondent.

When asked the question, *"In your opinion, how likely is it that the person's situation might be caused by his or her own bad character?",*

participants, who reported major depression "not likely" to be caused by one's own bad character, 81.4 percent were more willing to have that person as their neighbor than participants (71.3%) reporting it likely to be caused by bad character.

When asked whether person's situation depicted in both the major depression and schizophrenia vignettes are *likely caused by a chemical imbalance,* responses varied. Of those participants reporting major depression being likely caused by a chemical imbalance, 81.1 percent were willing to have a friendship with that person; however, for schizophrenia, 82.9 percent reported it not likely caused by a chemical imbalance and were still willing to have a friendship with that person. The likelihood of major depression being caused by a chemical imbalance also revealed a 78 percent willingness among respondents to have a group home in their neighborhood for people with major depression. However, in the case of schizophrenia, with a chemical imbalance being the likely cause, 88.5 percent of the respondents were not willing to work closely with that person, and 87.9 percent were not willing to have that person marry into their family.

When asked whether the person's situation depicted in the major depression vignette is *likely caused by the way he or she was raised,* 81.8 percent of the participants who reported "likely" were willing to have a friendship with that person.

When asked whether the person's situation depicted in the major depression vignette is *likely caused by genetics*, of those who reported "likely," 81.9 percent were willing to have that person as their neighbor. Eighty-three percent were willing to have a friendship with that person, 60.7 percent were willing to work closely with that person on the job, 77.4 percent were willing to have a group home in their neighborhood for people like that person, and 46 percent were willing to permit the person to marry into their family.

When asked whether the person's situation depicted in the schizophrenia vignette is *likely caused by God's will*, 81.6 percent of the participants who reported "likely" were willing to have a friendship with that person.

When asked the question, *"In your opinion, how likely is it that the person is experiencing the normal ups and downs of life,"* 68.4 percent of the participants who reported "not likely" with regard to the schizophrenia vignette were not willing to work closely with that person.

When asked whether the person depicted in the schizophrenia vignette is *likely experiencing a nervous breakdown*, 74.9 percent of the participants, who reported a breakdown "likely," were not willing to have that person marry into their family.

When asked whether the person depicted in the schizophrenia vignette is *likely experiencing a mental illness*, 65.8 percent of the participants who reported "likely" were not willing to work closely with

that person, but 69.7 percent were willing to have a group home in their neighborhood for people like that person.

Finally, when respondents were questioned whether the person depicted in the vignette was likely suffering from major depression or either schizophrenia, of those reporting schizophrenia as the correct label, 70.9 percent were willing to have a group home in their neighborhood for people with that illness. Of those participants reporting major depression as not the correct label, 92.9 percent were willing to socialize with that person.

CHAPTER 4

CONCLUSIONS

Methodological Problems

Data collected for the study reported here were limited to 1996; therefore, conclusions from this study are time bound. It is also believed that methodological problems exist within the structure of the 1996 Mental Health Module. In particular, the order in which questions were asked very likely affects the respondents' perception of the person depicted in the vignette. The fact of giving a behavioral description of the person depicted in the vignette followed by questions about the person's character and identification of the actual label, only then to follow with questions of willingness to associate with that person and finally perceived violence from that person, this researcher questions whether the preceding questions to those on willingness and perceived tendency toward violence did, in fact, persuade the respondents to have preconceived negative attitudes. These preconceived negative attitudes may have then affected the respondent's answers, which, in turn, made a substantial effect on the measurement of social distance from the

mentally ill. Therefore, it is likely that because of the design of this instrument, namely the order in which the social distance and perceived violence questions were asked, hypotheses on prior social contact with the mentally ill and social distance and/or perceived violence on the part of the mentally ill are not fairly measured.

Discussion of Findings

The primary focus of this research was to test whether prior social contact with the mentally ill was a strong predictor of preferred social distance from the mentally ill. In doing so, perceived tendency toward violence on the part of the mentally ill appeared in the review of the literature and led this researcher to hypothesize that there would be an inverse association between level of prior social contact and level of perceived tendency toward violence. In other words, as the level of prior social contact increases, the level of perceived tendency toward violence decreases or vice versa. This study found no significant findings to support the hypothesis. Hypothesis 1 was not supported because there is no association between prior social contact and perceived violence.

A possible explanation for the lack of association found for Hypothesis 1 is discussed in the methodological problems of this chapter. The idea that questions were structured in such a manner that they may have persuaded the respondents' answers to social distance questions along with perceptions of violence, this researcher believes that

prior social contact with the mentally ill could not be fairly measured as well.

Previously reviewed literature, indicating relationships between contact and attitudes toward mental illness, led this researcher to hypothesize that an inverse association between the level of prior social contact and preferred social distance from the mentally ill would be significant. Although results for Hypothesis 2 were not significant, tests did reveal that respondents having had close prior social contact with someone who was hospitalized for mental illness in general preferred less social distance from the mentally ill as was expected. Regardless, Hypothesis 2 was not supported.

Hypothesis 3 was supported. The results were statistically significant, which means there is a direct association between level of perceived tendency toward violence and preferred social distance. These data support Link's et al. (1999); Martin's et al. (2000); and Phelan's et al. (2000) results from previous research. In sum, widely held perceived dangerousness plays a role in the public's unwillingness to interact with people with mental illness; and replication and support for this study shows that there is continued public desire for social distance from people with mental health problems because of perceived tendency toward violence by the mentally ill.

This research is considered successful even though two of the hypotheses were not found to be statistically significant. While this

research demonstrates that stigma still exists as a societal reaction to mental illness as a result of perceived dangerousness, more importantly, it was suggested (not significant) that having prior social contact with the mentally ill would lessen one's preferred social distance from the mentally ill. In particular, it was suggested to be truer for those having a close prior social contact, meaning family, friend, and even the respondent him or herself, than those having casual prior social contact with the mentally ill. This suggests that it is experience, which is required from society in order to better define mental illness and accept the mentally ill. This social construct of mental illness sets the boundaries of normal, acceptable mental functioning in different cultures and societies and is very much a part of the social regulation of human conduct. In other words, mental illness is a form of social behavior, defined by society and learned through social experience.

Recommendations for Further Research

The literature review suggested a relationship between religious beliefs and attitudes toward mental illness. Earlier, this study sought to find similar associations but found none. The review of literature also suggested that media play a part in labeling mental illness; thus this researcher believed that religious beliefs (i.e., demon possession) are, at times, a stereotype used by the media to portray the mentally ill. Perhaps there is a relationship between religious beliefs and attitudes

toward mental illness. Future research could pursue an association between the two using a survey designed for different religious congregations coupled with a survey for mental patients themselves who have religious beliefs.

Because of the limitations of the GSS's 1996 Mental Health Module, this researcher believes that this study can be replicated, using its general framework but in a different ordered fashion, with one's own questionnaire and distributed among the public. It may be more interesting if a future researcher can obtain a sample from a younger population, such as junior high level or even younger to test one's level of prior social contact with the mentally ill based on the respondent's age and education in order to obtain a level of social distance from the mentally ill. Additionally, level of contact with the mentally ill associated with perceived tendency toward violence on the part of the mentally ill may provide information on whether experience is actually required in determining preferred social distance from the mentally ill.

REFERENCES

Anderson, Margaret L. and Howard F. Taylor. 2001. Sociology: The Essentials. Thomson Learning, Inc.

_____. 2001. Sociology: The Essentials. Thomson Learning, Inc. Quoting Peter L. Berger and Thomas Luckmann. 1967. The Social Construction of Reality: A Treatise in the Sociology of Knowledge. Garden City, NY: Anchor Books.

_____. 2001. Sociology: The Essentials. Thomson Learning, Inc. Quoting Herbert Blumer. 1969. Studies in Symbolic Interaction. Englewood Cliffs, NJ: Prentice Hall.

Becker, Howard S. 1963. Outsiders; Studies in the Sociology of Deviance. New York: Free Press.

Chou, Kee-Lee, Ki-Yan Mak, Po-Kin Chung and Kimmy Ho. 1996. "Attitudes Towards Mental Patients in Hong Kong." International Journal of Social Psychiatry 42:213-219.

Chung, K.F., Eric Y.H. Chen and Catherine S.M. Liu. 2001. "University Students' Attitudes Towards Mental Patients and Psychiatric Treatment." International Journal of Social Psychiatry 47:63-72

Cormack, Stephanie and Adrian Furnham. 1998. "Psychiatric Labelling, Sex Role Stereotypes and Beliefs about the Mentally Ill." The International Journal of Social Psychiatry 44:235-47.

Crocetti, Guido M., Herzl R. Spiro and Iradj Siassi. 1974. Contemporary Attitudes Toward Mental Illness. University of Pittsburgh Press.

Ellison, Christopher.G., Jason D. Boardman, David R. Williams, and James S. Jackson. 2001. "Religious Involvement, Stress, and Mental Health: Findings from the 1995 Detroit Area Study." Social Forces 80:215-249.

Goffman, Erving. 1963. Stigma: Notes on the Management of Spoiled Identity. Prentice Hall, Inc. Englewood Cliffs, New Jersey.

Gray, Allison J. 2001. "Attitudes of the Public to Mental Health: A Church Congregation." Mental Health, Religion and Culture 4:71-79.

Hannigan, Ben. 1999. "Mental Health Care in the Community: An Analysis of Contemporary Public Attitudes Towards, and Public Representations of, Mental Illness." Journal of Mental Health 8:431.

Huxley, Peter. 1993. "Location and Stigma: A Survey of Community Attitudes to Mental Illness Part II: Community Mental Health Facilities -- Anonymity or Invisibility." Journal of Mental Health 2:157.

Link, Bruce G., Jo. C. Phelan, Michaeline Bresnahan, Ann Stueve and Bernice Pescosolido. 1999. "Public Conceptions of Mental Illness: Labels, Causes, Dangerousness, and Social Distance." American Journal of Public Health 89:1328-33.

Martin, Jack K., Bernice A. Pescosolido and Steven A. Tuch. 2000. "Of Fear and Loathing: The Role of 'Disturbing Behavior', Labels, and Causal Attributions in Shaping Public Attitudes Toward People with Mental Illness." Journal of Health and Social Behavior 41:208-223.

Ng, Petrus and Kai-Fong Chan. 2000. "Sex Differences in Opinion Towards Mental Illness of Secondary School Students in Hong Kong." International Journal of Social Psychiatry 46:79.

Norman, R.M.G. and A.K. Malla. 1983. "Adolescents' Attitudes Towards Mental Illness: Relationship Between Components and Sex Differences." Social Psychiatry 18:45-50.

Nunnally, J. 1961. Popular Conceptions of Mental Health: Their Development and Change. Holt, Rinehart, and Winston. New York, New York.

Page, Robert. 1984. Stigma. Routledge and Kegan Paul plc. Quoting R.W. English. "Correlates of Stigma Towards Physically Disabled Persons." Marinelli, R.P. and Dell Orto, A.E. (eds).

Phelan, Jo C., Bruce G. Link, Ann Stueve, and Bernice A. Pescosolido. 2000. "Public Conceptions of Mental Illness in 1950 and 1996: What is Mental Illness and Is It to be Feared?" Journal of Health and Social Behavior 41:188-207.

Rabkin, Judith. 1972. "Opinions about Mental Illness: A Review of the Literature." Psychological Bulletin 77:153-71.

Read, John and Alan Law. 1999. "The Relationship of Causal Beliefs and Contact with Users of Mental Health Services to Attitudes to the Mentally Ill." The International Journal of Social Psychiatry 45:216-29.

Rosenberg, Gary and Lisa Attinson. 1977. "Attitudes Toward Mental Illness in the Working Class." Social Work in Health Care 3:77-86.

Rosenfield, Sarah. 1997. "Labeling Mental Illness: The Effects of Services Versus Stigma." American Sociological Review 62:660-672.

Scheff, Thomas J. 1967. Mental Illness and Social Processes. Harper and Row, Publishers, Incorporated. New York, New York.

_____. 1975. Labeling Madness. Prentice Hall, Inc. Englewood Cliffs, New Jersey.

_____. 1984. Being Mentally Ill. Aldine Publishing Company. Hawthorn, New York.

Schnittker, Jason. 2000. "Gender and Reactions to Psychological Problems: An Examination of Social Tolerance and Perceived Dangerousness." Journal of Health and Social Behavior 41:224-240.

Smart, Julie. 2001. Disability, Society, and the Individual. Aspen Publishers, Inc.

Star, Shirley. 1955. "The Public's Ideas About Mental Illness." Chicago: National Opinion Research Center.

Wolf, Pathare, Craig, and Leff. 1996. "Community Knowledge of Mental Illness and Reaction to Mentally Ill People." British Journal of Psychiatry 186:1919-198.

Table 1. Characteristics of Respondents in Survey.

Characteristics of Respondents	Major Depression Response Frequency (n=300)	%	Schizophrenia Response Frequency (n=301)	%
Demographic Characteristics:				
Age				
18-29	73	24.3	56	18.6
30-39	71	23.7	72	23.9
40-49	68	22.7	72	23.9
50-59	30	10.0	42	14.0
60-69	28	9.3	23	7.6
70-79	22	7.3	22	7.3
80-89	8	2.7	14	4.7
Gender				
Male	139	46.3	147	48.8
Female	161	53.7	154	51.2
Ethnicity				
White	237	79.0	257	85.4
African-American	50	16.7	30	10.0
Other	13	4.3	14	4.7
Marital Status				
Married	152	50.7	168	55.8
Not Married	148	49.3	133	44.2
Education Level				
Less than College	162	66.4	163	62.5
College	82	33.6	98	37.5
Income				
$1,000-9,999	31	11.7	30	11.7
$10,000-19,999	42	15.8	44	17.2
$20,000-24,999	19	7.1	22	8.6
$25,000 or more	174	65.4	160	62.5
Religion Raised				
Protestant	194	64.7	175	58.1
Catholic	81	27.0	89	29.6
Other	12	4.0	20	6.6
None	13	4.3	17	5.6
Prior Social Contact Levels:				
Prior Social Contact				
Close	66	97.1	65	91.5
Casual	2	2.9	6	8.4
Relationship to the Mentally Ill				
Self	1	.3	6	8.5
Family	39	57.4	38	53.5
Close Friend	26	38.2	21	29.6
Relative	1	1.5	4	5.6
Acquaintance	1	1.5	2	2.8

Table 1 cont. Characteristics of Respondents in Survey.

Characteristics of Respondents	Major Depression Response Frequency (n=300)	%	Schizophrenia Response Frequency (n=301)	%
Perceived Tendency Toward Violence:				
Likely to Hurt Others				
Likely	94	33.3	162	60.9
Not Likely	188	66.7	104	39.1
Likely to Hurt Self				
Likely	215	74.9	238	86.5
Not Likely	72	25.1	37	13.5
Preferred Social Distance Levels:				
Social Distance Scale				
0 = Low Social Distance	58	23.5	38	15.3
1	45	18.2	39	15.7
2	38	15.4	37	14.9
3	43	17.4	37	14.9
4	26	10.5	33	13.3
5	20	8.1	35	14.1
6 = High Social Distance	17	6.9	30	12.0
Social Distance re: Willingness				
Have as a neighbor				
Willing	223	77.2	172	62.1
Not willing	66	22.8	105	37.9
Socialize				
Willing	187	64.3	147	51.0
Not willing	104	35.7	141	49.0
Have a friendship				
Willing	219	76.8	186	66.0
Not willing	66	23.2	96	34.0
Work closely on a job				
Willing	145	51.4	101	36.9
Not willing	137	48.6	173	63.1
Have a neighborhood group home				
Willing	194	68.8	187	66.8
Not willing	88	31.2	93	33.2
Marry into the family				
Willing	106	39.4	75	27.8
Not willing	163	60.6	195	72.2

Table 2. Mean Perceived Tendency Toward Violence by Level of Prior Social Contact.

Hypothesis 1: There is an Inverse Association Between Level of Prior Social Contact and Level of Perceived Tendency Toward Violence on the part of the mentally ill.

Prior Contact	Mean Perceived Tendency Toward Violence		
	Number	Mean	Difference
Likely to Hurt Others			
Major Depression			
Close Prior Contact	65	1.65	.15
Casual Prior Contact	2	1.50	.15
Schizophrenia			
Close Prior Contact	57	1.42	.17
Casual Prior Contact	4	1.25	.17
Likely to Hurt Self			
Major Depression			
Close Prior Contact	66	1.17	.17
Casual Prior Contact	2	1.0	.17
Schizophrenia			
Close Prior Contact	59	1.10	.10
Casual Prior Contact	4	1.0	.10

Table 3. Mean Preferred Social Distance by Prior Contact.

Hypothesis 2: There is an Inverse Association Between Level of Prior Social Contact and Level of Preferred Social Distance from the Mentally Ill.

Prior Contact	Mean Preferred Social Distance		
	Number	Mean	Difference
Major Depression			
Close Prior Social Contact	52	2.27	1.23
Casual Prior Social Contact	2	3.50	1.23
Schizophrenia			
Close Prior Social Contact	56	2.46	.46
Casual Prior Social Contact	3	2.00	.46

Table 4. Chi-Square: Crosstabulation of Preferred Social Distance and Perceived Tendency Toward Violence (likely to hurt others).

Hypothesis 3: There is a Direct Association Between Level of Perceived Tendency Toward Violence and Preferred Social Distance from the Mentally Ill.

Major Depression: Likely to Hurt Others. *P<.05

			likely to hurt others		
			Likely	Not Likely	Total
Preferred Social Distance Scale	0 = Low Social Distance Score	Count	9	49	58
		% within Preferred Social Distance Scale	15.5%	84.5%	100.0%
		% within likely to hurt others	10.5%	31.4%	24.0%
		% of Total	3.7%	20.2%	24.0%
	1	Count	19	25	44
		% within Preferred Social Distance Scale	43.2%	56.8%	100.0%
		% within likely to hurt others	22.1%	16.0%	18.2%
		% of Total	7.9%	10.3%	18.2%
	2	Count	13	24	37
		% within Preferred Social Distance Scale	35.1%	64.9%	100.0%
		% within likely to hurt others	15.1%	15.4%	15.3%
		% of Total	5.4%	9.9%	15.3%
	3	Count	14	28	42
		% within Preferred Social Distance Scale	33.3%	66.7%	100.0%
		% within likely to hurt others	16.3%	17.9%	17.4%
		% of Total	5.8%	11.6%	17.4%
	4	Count	13	13	26
		% within Preferred Social Distance Scale	50.0%	50.0%	100.0%
		% within likely to hurt others	15.1%	8.3%	10.7%
		% of Total	5.4%	5.4%	10.7%
	5	Count	9	11	20
		% within Preferred Social Distance Scale	45.0%	55.0%	100.0%
		% within likely to hurt others	10.5%	7.1%	8.3%
		% of Total	3.7%	4.5%	8.3%
	6 = High Social Distance Score	Count	9	6	15
		% within Preferred Social Distance Scale	60.0%	40.0%	100.0%
		% within likely to hurt others	10.5%	3.8%	6.2%
		% of Total	3.7%	2.5%	6.2%
Total		Count	86	156	242
		% within Preferred Social Distance Scale	35.5%	64.5%	100.0%
		% within likely to hurt others	100.0%	100.0%	100.0%
		% of Total	35.5%	64.5%	100.0%

a. separate md&s = Major Depression

Chi-Square Tests [b]

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	18.436[a]	6	.005
Likelihood Ratio	19.504	6	.003
Linear-by-Linear Association	11.477	1	.001
N of Valid Cases	242		

a. 0 cells (.0%) have expected [illegible]

Table 5. Chi-Square: Crosstabulation of Preferred Social Distance and Perceived Tendency Toward Violence (likely to hurt others).

Hypothesis 3: There is a Direct Association Between Level of Perceived Tendency Toward Violence and Preferred Social Distance from the Mentally Ill.

Schizophrenia: Likely to Hurt Others. *P<.01

			likely to hurt others		
			Likely	Not Likely	Total
Preferred Social Distance Scale	0 = Low Social Distance Score	Count	12	24	36
		% within Preferred Social Distance Scale	33.3%	66.7%	100.0%
		% within likely to hurt others	8.1%	27.9%	15.4%
		% of Total	5.1%	10.3%	15.4%
	1	Count	19	17	36
		% within Preferred Social Distance Scale	52.8%	47.2%	100.0%
		% within likely to hurt others	12.8%	19.8%	15.4%
		% of Total	8.1%	7.3%	15.4%
	2	Count	22	12	34
		% within Preferred Social Distance Scale	64.7%	35.3%	100.0%
		% within likely to hurt others	14.9%	14.0%	14.5%
		% of Total	9.4%	5.1%	14.5%
	3	Count	21	15	36
		% within Preferred Social Distance Scale	58.3%	41.7%	100.0%
		% within likely to hurt others	14.2%	17.4%	15.4%
		% of Total	9.0%	6.4%	15.4%
	4	Count	21	12	33
		% within Preferred Social Distance Scale	63.6%	36.4%	100.0%
		% within likely to hurt others	14.2%	14.0%	14.1%
		% of Total	9.0%	5.1%	14.1%
	5	Count	29	4	33
		% within Preferred Social Distance Scale	87.9%	12.1%	100.0%
		% within likely to hurt others	19.6%	4.7%	14.1%
		% of Total	12.4%	1.7%	14.1%
	6 = High Social Distance Score	Count	24	2	26
		% within Preferred Social Distance Scale	92.3%	7.7%	100.0%
		% within likely to hurt others	16.2%	2.3%	11.1%
		% of Total	10.3%	.9%	11.1%
Total		Count	148	86	234
		% within Preferred Social Distance Scale	63.2%	36.8%	100.0%
		% within likely to hurt others	100.0%	100.0%	100.0%
		% of Total	63.2%	36.8%	100.0%

a. separate md&s = Schizophrenia

Chi-Square Tests [b]

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	34.023[a]	6	.000
Likelihood Ratio	37.353	6	.000
Linear-by-Linear Association	29.415	1	.000
N of Valid Cases	234		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 9.56

Table 6: Mean Preferred Social Distance by Perceived Tendency Toward Violence.

Hypothesis 3: There is a Direct Association Between Level of Perceived Tendency Toward Violence and Preferred Social Distance from the Mentally Ill.

Perceived Violence	Mean Preferred Social Distance		
	Number	Mean	Difference
Major Depression			
Hurt Others			
Likely	86	2.77	.84*
Not Likely	156	1.92	.84*
Hurt Self			
Likely	181	2.33	.36
Not Likely	61	1.97	.36
Schizophrenia			
Hurt Others			
Likely	148	3.37	1.44*
Not Likely	86	1.93	1.44*
Hurt Self			
Likely	207	2.86	.26
Not Likely	33	2.61	.26

*P<.01

VITA

Stacey Fondren was born in Beaumont, Texas, on October 30, 1968, the daughter of Bill and Shirley Fondren. After graduating from Lumberton High School, Lumberton, Texas, in 1987, she entered Lamar University in Beaumont, Texas. One year later, she entered Alvin Community College in Alvin, Texas, to study court reporting, where she obtained her Associate degree in 1993, and subsequently began freelance reporting in Tallahassee, Florida. In 1996, she moved to Phoenix, Arizona, and obtained a lead instructor position at Metropolitan College of Court Reporting, and, at the same time, obtained her Bachelor of Science in Court Reporting (one of the few colleges in the Nation to offer this degree). In 1998, she returned to Texas and entered Lamar University yet again, only to transfer her senior year in Business Administration to Southwest Texas State University in San Marcos, Texas, in 2000. At this time, she changed her major to Sociology and obtained her Bachelor of Applied Science degree in May of 2001. In the Fall of 2001, she entered the Graduate School of Southwest Texas State University. During 2001-2003, Stacey worked as a graduate assistant in the Department of Sociology at SWTSU. In particular, she assisted in running the Sociology Department's internship program.

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