



Minnesota State University, Mankato
Cornerstone: A Collection of Scholarly
and Creative Works for Minnesota
State University, Mankato

All Graduate Theses, Dissertations, and Other
Capstone Projects

Graduate Theses, Dissertations, and Other
Capstone Projects

2012

Mental Illness and Stigmatization

Struther Louise Van Horn
Minnesota State University - Mankato

Follow this and additional works at: <https://cornerstone.lib.mnsu.edu/etds>



Part of the [Medicine and Health Commons](#)

Recommended Citation

Van Horn, S. L. (2012). Mental Illness and Stigmatization [Master's thesis, Minnesota State University, Mankato]. Cornerstone: A Collection of Scholarly and Creative Works for Minnesota State University, Mankato. <https://cornerstone.lib.mnsu.edu/etds/244/>

This Thesis is brought to you for free and open access by the Graduate Theses, Dissertations, and Other Capstone Projects at Cornerstone: A Collection of Scholarly and Creative Works for Minnesota State University, Mankato. It has been accepted for inclusion in All Graduate Theses, Dissertations, and Other Capstone Projects by an authorized administrator of Cornerstone: A Collection of Scholarly and Creative Works for Minnesota State University, Mankato.

Mental Illness and Stigmatization

By

Struther Van Horn

A Thesis Submitted in Partial Fulfillment of the

Requirements for the Degree of

Master of Arts

In

Sociology

Minnesota State University, Mankato

Mankato, Minnesota

August, 2012

Mental Illness and Stigmatization

Struther Van Horn

This thesis has been examined and approved by the following members of the thesis committee.

Dr. Steven Vassar, Advisor

Dr. Barbara Keating

Dr. Jasper Hunt

Abstract

Mental Illness and Stigmatization, by Struther Van Horn, is done in partial fulfillment of the requirements of the degree Master of the Arts for Minnesota State University, Mankato. The purpose of this study is to examine the relationship between mental illness and stigmatization. For most of the twentieth century, popular attitudes towards the mentally ill were overtly negative and stigmatizing. In the 1970s-1980s, however, a putative shift in perceptions—thought to be the result of increased public knowledge about psychological disorders—purportedly diminished the stigma attached to mental illness. Using race, gender, and age as moderating variables, this study draws upon data from the recent 2006 General Social Survey to reexamine more current attitudes by the public towards those with mental illness and how it affects the desire for social distance from those with mental illness. Hypotheses looked at in this study are: 1. The closer the relationship to a person with mental illness, the lesser the desire of social distance. 2. The younger the participant, the lesser desire for social distance. 3. Women will have a lesser desire for social distance than men. 4. Non-white participants will have a lesser desire for social distance than whites. Statistical analysis did not confirm the hypotheses set forth in the study.

Acknowledgements

This thesis would not have been possible without the help and support of many people; it is to them that that I owe my deepest gratitude:

First and foremost to my advisor Dr. Steven Vassar, a mentor and friend, for pushing me when things got rough, for always encouraging me to pursue my academic endeavors, for being there with thoughtful ideas and suggestions, and most importantly helping me reach my goals.

To my committee member Dr. Barbra Keating, for your encouraging words, thoughtful constructive criticism, time, and helping further my academic pursuits.

To Dr. Catarina Fritz, for all the hours you spent talking with me about my academic passions and pushing me down the right path with my literature review and studies.

To Dr. William Wagner, for all of your statistical knowledge and assistance on this project.

To Dr. Vicki Hunter, for all of your time and help over the course of my progress through the program and for helping further my academic pursuits.

To my committee member Dr. Jasper Hunt, for your time and thoughtful ideas.

And lastly, to my mother, Ruth Dutler, for helping encourage and support me while I finished this project.

TABLE OF CONTENTS

CHAPTERS

I. INTRODUCTION	1
Literature review	4
Current Research	15
II. METHODOLOGY.....	23
Hypotheses.....	27
Analysis.....	28
III. RESULTS	29
Characteristics of sample.....	29
Closeness to mental illness and desire for social distance (Hypothesis #1).....	31
Age as moderating variable (Hypothesis #2).....	37
Gender as moderating variable (Hypothesis #3).....	47
Race as moderating variable (Hypothesis #4).....	57
IV. DISCUSSION	68
Significance of findings	69
Limitations and future work	70
Conclusions.....	71
REFERENCES	72

Introduction

Mental illness has been a ubiquitous part of the human condition from the beginning of recorded history. It is almost impossible to estimate how many individuals, families, and communities it has affected. Over the course of the last 100 years, medical advances and novel treatments for those with mental illnesses have changed drastically. Indeed, with a combination of medication and other treatments, many people with mental illnesses can now enjoy lives that are largely indistinguishable from the rest of the population. Despite these recent developments, people who suffer from mental illness are still met with hostility, banishment, and even neglect at the societal level. At the emotional level, people are fearful, hateful, and even pity those with mental health problems. The lack of empathy, respect, and fairness of treatment for people suffering from mental illnesses all suggest deeper problems.

In one respect, it would seem that people in our society are becoming more tolerant of those with mental illness. More and more, those who live in the public spotlight are coming out and talking about their experiences with mental illness. Celebrities and other famous people are openly discussing their experiences with drug and alcohol abuse (Charlie Sheen, Robert Downy, Jr., etc.). Brook Shields talked about dealing with post-partum depression, Jane Pauley was open with her problems with bipolar disorder, and Owen Wilson has discussed his battles with suicide. Star athlete Alex Rodriguez came forward and spoke about his experiences with therapy. Even the

general public now seems more likely to talk about their experiences with mental illness, but have we in fact entered an era of tolerance?

It was not until 1999 that President Bill Clinton and Tipper Gore sponsored the first ever White House conference on mental health. This was the first time that the goal of treating those with mental illness with the same respect as those suffering from physical illnesses was explicitly stated to the public. This event and other nations' national-level public-awareness campaigns seemed to be encouraging acceptance (Hinshaw, 2007). Indeed, these events were understood at the time as signs that a change towards the treatment of those with mental illness was on the horizon. But, has a shift in perceptions towards those suffering from mental illness really occurred?

Despite the medical and public awareness advances made, those with mental illness continue to be discriminated against in many different ways. Equal opportunities for gaining employment and housing are not often found for those who admit to having a mental illness. Getting a driver's license, gaining custody of a child, or even having the right to vote can all be difficult, or impossible tasks for those who have a mental illness. Often times, just admitting there has been a history of a mental disorder, not actual documentation of a disorder, can trigger discrimination. Insurance coverage for mental health treatment has been notoriously unequal—lagging far behind the coverage offered for physical illnesses. And, research funding available for studying treatments for, and causes of, mental illnesses is still behind funding available for physical illness research (Hinshaw, 2007).

This study seeks to take another look at whether or not public attitudes have shifted towards those who have mental illness. It is important to try to understand whether or not increased public exposure and knowledge has in fact influenced perceptions towards those with mental illness. By using more current data, provided by the 2006 General Social Survey (GSS), this study will look at how close respondents are to someone with mental illness and their desire for social distance.

Literature Review

What is Stigmatization?

In order to analyze stigmatization, it is important to distinguish it from stereotyping, prejudice, and discrimination. While some overlap exists between all of these terms, distinguishing the differences between them leads to a better understanding of what exactly stigmatization is. Stereotyping occurs when beliefs are made about a particular social group. These beliefs are made in an “all-or-nothing fashion, characterizing a group as a whole while dismissing individual differences or the unique characteristics of persons within the group” (Hinshaw, 2007:21). An example of this would be assuming that all members of a certain ethnic group are lazy, pushy, or hostile. Another example would be that people with a physical disability are in some way incapable and need help. Or that all Asian people are good at mathematics. Yet another example of a stereotype is that all mentally ill people are dangerous.

The idea behind stereotyping is that we need some sort of system to make judgments quickly in our social world, in order to conserve our cognitive efforts. We use these snap judgments to assess groups of people quickly. While stereotypes can be rooted in some truths, they are generally inaccurate generalizations—obfuscating both individuals and their realities—about a group of people, whether or not they are positive or negative judgments. When stereotypes ignore information that contradicts

popular beliefs, pushing out new information regarding individuals or their groups, they become prejudices.

Becoming so rigid that they ignore information about the group, or individuals within the group, stereotypes take on a negative aspect. These negative beliefs turn into a prejudice. Prejudices can be defined as, “unreasoning, unjustifiable, overgeneralized, and negatively tinged attitudes towards others related to their group membership. The term literally connotes prejudgment, reflecting ascriptions made about members of a social group in the absence of evidence” (Hinshaw, 2007:22). These attitudes can be based on gender, religion, social class, age, race, or membership in any other type of group. Whereas stereotypes can reflect positive or negative perceptions about particular groups, prejudices tend to have negative assumptions and are not always based upon actual experience. When people are actually treated differently due to prejudices, we see discrimination.

Discrimination occurs when people act unfairly towards others due to their membership in a particular group. Discrimination can be practiced by individuals, groups, or even society as a whole. The outcome is that the group that is discriminated against has limited rights. Racial discrimination is a prime example. In this instance, people of a particular racial group face devaluation and limited rights solely because of their membership in that group. Stereotyping is cognitive where we make broad generalizations that we use to categorize groups. With prejudice, we see the emotional impact of stereotypes due to the devaluation of people due to their group membership.

Discrimination is the actual behavioral response of prejudice, where members of a given group can be outright harmed and have their rights limited (Hinshaw 2007).

The origins of stigma come from historical practices of actually branding people who belonged to dishonored and/or ostracized groups so they had a visible marker of this disgrace. This ensured that all people knew of the individual's disgraced status. In *Stigma: Notes on the Management of Spoiled Identity* (1963), Erving Goffman examines the origins of stigma in ancient Greece, where stigmatization referred to "bodily signs designed to expose something unusual and bad about the moral status of the signifier: The signs were cut or burnt into the body and advertised that the bearer was a slave, a criminal, or a traitor- a blemished person, ritually polluted, to be avoided especially in public places" (1963:1).

Current definitions of stigma deal with attitudes of degradation and shame more than physical markings. Goffman contended that when we place a stigma on a people, we see them as less than human. When we do this, we are placing discrimination onto them and reduce their life chances. We construct a theory to explain why people are inferior and to express the danger we see them representing. We also place a wide range of imperfections onto these people because of the original imperfection. "We may perceive his defensive response to his situation as a direct expression of his defect, and then see both defect and response as just retribution for something he or his parents or tribe did, and hence a justification for how we treat him" (1963:6).

Stigmatization incorporates elements from stereotypes, prejudice, and discrimination. Stereotyping occurs when a person is perceived as a member of a group and, because of that group membership, is thought to possess the group's identity, regardless of the individual's actual characteristics. Prejudice is present because the perceived attitudes are often negative in nature. Discrimination is present because the stigmatized individual is shunned, excluded, and punished by society. Stigmatization, however, goes beyond these attitudes. Stigma is so pervasive that it can even affect those associated with the stigmatized individual. Because those people who are associated with a stigmatized individual (family members, work partners, friends, etc.) can also experience courtesy stigma, it is more than the attitudes and responses of stereotyping, prejudice, and discrimination.

Stigmatization can be viewed as a social process. First a perceiver recognizes a difference that identifies a person as a member of an out-group. This recognition turns into stigmatization because there is a devaluation of the characteristic or group identity the individual has. The person is viewed as intrinsically flawed due to this characteristic exactly negative traits are associated with this characteristic. Once individuals are stigmatized, they are not likely to get rid of that label. The global quality of stigmatization makes it likely that once an individual is labeled as stigmatized, they will be excluded from many forms of social exchanges and discriminated against. "Through the stigma process, the flaw is magnified until it comes to reduce the individuality and even the humanity of the targeted person.... The reduction of individuality that accrues

from stigmatization may lead to perceptions of a person's reduced humanity as well" (Hinshaw, 2007:26).

Stigma equals a deep mark of shame and degradation that a person carries due to being a member of a devalued social group. People in society come to think of this person solely in terms of this flawed identity and all characteristics are understood through the stigmatized identity. Stigma processes can also involve self-stigmatization. Self-stigmatization is where the stigmatized groups or individual internalize the negative messages they receive, which can lead to secrecy and concealment (Corrigan and Watson, 2002). Finally stigmatization can lead to a less-than-human status, which acts as a justification for the extreme responses society has against the stigmatized groups (Hinshaw, 2007).

Stigma and Mental Health

In a study by Lamy (1966), undergraduate students were asked to make snap judgments of two different groups: ex-mental patients and ex-convicts. The participants were more likely to perceive ex-convicts as being more reliable than ex-mental patients. They believed ex-mental patients were less reliable in jobs that had high responsibility, and believed that if a mother needed child care for a weekend, she should choose an ex-convict over an ex-mental patient. Tringo (1970) asked participants to rank 21 different disability groups in order of social distance they would want from that group. Mental patients were ranked dead last. Mental patients were more rejected than dwarfs, ex-

convicts, hunchbacks, and people with mental retardation. These two studies help illustrate that being categorized mentally ill is among the worst labels in our society.

Since the 1940s to 1950s, scholars have researched popular attitudes towards mental disorders. Early studies focused on presenting participants with vignettes that described different mental disorders, while asking participants to express feelings, desired social distance, and knowledge about mental disorders. Typically, participants have demonstrated a large degree of stigmatization and desire for social distance. Whatley (1958) used the social distance scale, a measure to assess the amount of desired contact with, or distance from, an individual to look at participants' attitudes about persons who had been in a mental hospital. The items that were on the social distance scale included: living near, hiring, having as a neighbor, having the individual as a roommate, hiring as a babysitter, or having one's offspring marry the individual in question. The results showed that while many of the participants did not seem to have a problem living near a mental patient, the majority rejected any closer social contact. The strongest rejection came when participants were asked about having their offspring marry a mental patient, or having that person as a babysitter. Respondents who were younger, and those with higher amounts of education, had slightly lower levels of social rejection and distancing than those who were older and/or had less education, but overall respondents did not want close relationships with individuals labeled as mentally ill. Phillips (1966) demonstrated the power of the label of mental disorder in his study. He gave respondents normal-range behavioral descriptions, paired with the description of never having sought professional help, and the same behavioral descriptions paired

with the description of ex-mental patient. The results showed that with the description of never having received professional help, there was minimal social distance. But, when the same normal behaviors were associated with ex-mental patients, social distance increased dramatically. Indeed, only a few said they would rent a room to the individual and less than 20% wanting the described individual to marry their son or daughter. Phillips study illustrates that even when there are no abnormal behaviors being described, the label of ex-mental patient alone produces stigmatization in the public.

While some studies linked lower education of respondents with stigmatizing beliefs, the stigmatizing effect was not just limited to those with lower education. An example of this is a study done by Nunnally (1961). Nunnally did a nationally representative study on 400 adults, who responded to a number of different questions on mental disorders. The outcome of this study was that while people of higher education were more informed about mental disorders, attitudes about those with mental disorders were no different than those respondents with lower education levels. The overall attitude, regardless of education, was negative towards those with mental illnesses. The respondents understood those with mental illnesses to be dirty, dangerous, worthless, unpredictable and undependable.

Spiro, Siassi and Crocetti (1974) examined a blue collar population's contact with those who have mental illness. This study aimed to test whether or not the general population avoided social contact with those who have a mental illness. They

interviewed 937 members of the United Auto Workers Union and their spouses in Baltimore. The population of respondents was rather homogenous, with the typical respondent being a 40-year-old white male with around a ninth grade education level. The results of this study showed that 85% of the participants knew at least one person who had either seen a psychiatrist or been hospitalized for a mental illness. Most of the contacts reported by the respondents were either relatives or close friends. The conclusion of this study was that the general public did not in fact desire social distance due to the fact that such close relationships were had by the respondents with people who had mental health problems. This study does not look at whether or not the participants knew about their friends' mental health problems prior to starting a relationship, which could be a factor on desire for social distance. Overall, this study helps show that the closer one is to someone with a mental disorder, the less likely you are to stigmatize or desire social distance.

The general idea was that if the public could gain more knowledge about mental disorders, that there would be less stigmatization. This resulted in a public campaign by the government to foster public knowledge that mental disorders were indeed illnesses. "By 1980 a workshop convened by the National Institute of Mental Health on attitudes toward mental disorder eliminated the word stigma from its title, in response to the perception that improved attitudes and reduced prejudice were now the norm" (Hinshaw, 2007:98). The overall perception was that the negative attitudes towards mentally ill people were disappearing. However, not all researchers shared this viewpoint.

Researchers who disagreed with the perception that stigmatizing attitudes had diminished believed that people were just being more aware of what was socially acceptable and altering their responses accordingly. Link and Cullen (1983) pursued this possibility by having respondents answer questions about vignettes describing disturbed behavior in three different instructional sets. The first set asked what most people would feel about the person in question, the second set asked what an ideal person would feel about the person in question, and the last set asked how the respondent felt about the person in question. The hypothesis was that the set asking about what most people would feel about the person in question, would help describe the underlying attitudes of the respondents. The results were that when a vignette included a history of mental hospitalization history, there was a high desire of social distance, especially in the set where the respondents were asked what most people would feel. This research helped illustrate that while people were aware that they should not hold stigmatizing attitudes, the underlying attitudes were still present.

Employing a mail survey, Link and Cullen (1986) conducted a study examining how different types of contact may influence attitudes towards mental illness. They examined voluntary contact with mental illness, such as working with mental patients, as opposed to involuntary contact, such as having a family member in a mental facility. The initial thought was that voluntary contact would foster more positive attitudes due to the respondents choosing to work with those who have mental illness. The results of this study found no significant difference between those in the more voluntary group

versus the involuntary group. This study suggests that contact alone will affect attitudes towards then mentally ill, whether it is voluntary or not.

In a study spanning from the 1970s to the 1990s, Page (1995) reexamined behaviors towards those labeled as mentally ill. In this study, Page had staff members make telephone calls to landlords who had advertised that they had rooms for rent. The callers were randomly assigned to one of two conditions. In the first condition, they were just to inquire about the room. In the second condition, the callers added a sentence after the inquiry saying that they were receiving mental health treatment in a hospital and would soon need a place to live upon being release. Results were clear across the 1970s, 80s and 90s—if the callers indicated they were receiving treatment, only a small percentage of landlords responded by saying their rooms were still available, as opposed to those who just indicated interest in the room. This study illustrates that attitudes, and overt discrimination, towards those labeled as mentally ill have not changed over time.

In a Harris Poll that inquired about the public's attitudes towards disabilities in 1999, Americans ranked people with mental disorders as the individuals they were least comfortable with. They ranked people with facial disfigurements, deaf individuals, and people in wheelchairs higher than those with mental disorders (Hinshaw, 2007). Just as in Tringo's study in the 1970s, mental illness was still the most disturbing type of disability for the general public; again illustrating that stigmatization of mental illness has not changed much in several decades. In an updated vignette study, Link et al.

(1999b) administered descriptors of mental disturbances to more than 1,400 participants through the General Social Survey. The purpose is to provide descriptors of different mental disturbances and to see if the participants can correctly label them (such as schizophrenic, depression, drug addiction, etc.) and to assess corresponding beliefs and attitudes about mental illness. They found that 88% of the participants identified the schizophrenia vignette as describing a person with mental illness, 69% identified the major depression vignette as describing a person with a mental illness, and 49% and 44% for alcohol and cocaine dependence. These numbers are much higher than the vignettes were administered in the 1950s. The results as far as attitudes associated with this study showed that rates of desired social distance have increased since the 1950s. Link, Monahan and Cullen (1999a) explained that the reasoning behind this trend of increased desire for social distance is that more respondents 12% were likely to associate mental illness with dangerousness, as compared to the 5% of respondents in the 1950s that linked dangerousness with mental illness. "... gains in knowledge over the last few decades appear to have been accompanied by *increases* rather than decreases in stigmatization, at least for severe forms of mental disorder (Hinshaw, 2007:103).

Current Research

Martin, Pescosolido, and Tuch (2000) looked at attitudes towards people with mental illnesses and examined the public's willingness to interact with people who have mental problems. The researchers examined the ways that could influence the public's willingness by using five factors: the nature of the mental behavior described, causal attribution of the behavior's source, the perceived dangerousness of the person, the label of mental illness, and the sociodemographic characteristics of the respondents. The data used for this study was the same used from the 1996 General Social Survey (GSS) (Davis and Smith, 1996). The 1996 GSS had a special topic on mental health, the MacArthur Mental Health Module. The dependent variable, the preference for social distance from people with mental health problems, was measured by six social distance items. These items ranged from whether the respondent would move next door to a person with a mental illness, make friends with that person, and work with that person, to having the individual marry into the respondent's family.

Causal attributions of the causes of mental health problems were assessed by responses to six Likert-scale questions referencing the social, medical/genetic, moral and, individual causes of the condition. The respondents then indicated how likely it was the person in the question situation was caused by: his or her own character, a chemical imbalance in the brain, the way he or she was raised, a genetic or inherited problem, and God's will. For each of these causal attributions, the respondents answers

were coded a 1 if they answered “very likely” or “somewhat likely” and 0 if they answered “not very likely” or “not at all”.

Sociodemographic factors that were used in this study were: age (measured in years), gender, race (1 for Whites and 0 for Blacks and others), family income (ranging from 1 = under \$1,000 to 21 = \$75,000 and over per year), education (measured in years), region of residence (1 = resided in a region non-South and 0= residence of Southern states), and size of place of residence (1= large city of 250,000 or over to 10 = people residing in open country).

Results of this study found that the highest level of social distance is desired from those people who were thought to have substance abuse problems, either alcohol or drug dependency. Almost half of the respondents (48.4%) desired social distance from those who have schizophrenia or major depression. While only 38.2% of respondents actually said they would be unwilling to be friends with a person having any type of mental health problems. This willingness does not extend to having those with mental health problems as co-workers or family members. Overall, the sociodemographic characteristics of the respondents did not have a significant role on the amount of social distance desired. This study helped illustrate that, while a certain willingness to be around the mentally ill may have been initially present, the perceived level of dangerousness and tendency to attribute individual causes to the problem led to a very high desire for social distance.

Corrigan et al. (2001) looked at the relationship between familiarity with mental illness and prejudice/desire for social distance, as well as how ethnicity may play a role. They used 151 participants from community colleges. Participants completed three different measures that examined familiarity, prejudicial attitudes, and desire for social distance. Familiarity with mental illness was assessed by looking at 12 different situations, which vary in intimacy with mental illness. They ranged from observing someone with a mental illness, working with those with mental illness, to having a mental illness. Prejudicial attitudes were assessed by using a 70 statement questionnaire about the treatment and presentation of mental illness. Social distance was measured by a Social Distance Scale (SDS). The SDS has 7 items where participants rate how willing they are to have varying types of contact with those with mental illness. Ethnicity was coded into 1 = white and 0 = non-white.

The results of this study found that prejudicial attitudes towards those with mental illness led to a greater desire for social distance. Individuals who had more familiarity with mental illness were less likely to have prejudicial attitudes and, in turn, have less desire for social distance. They also found that participants from a minority ethnic group were much less likely to have prejudicial attitudes about the mental illness and a less desire for social distance. This study helps show how different factors, such as minority status, and familiarity can influence the desire for social distance from those with mental illness.

Penn et al. (2001) examined the effects of familiarity with mental illness on desires for social distance, feelings of fear, and perceptions of dangerousness. A total of 208 college students completed three different written measurements, which assessed familiarity with mental illness, perceptions of fear, and sense of dangerousness related to people who have mental illnesses. It also employed a desired social distance scale from people who have mental illnesses. The familiarity scale consisted of 12 different items ranging from not having any experience or exposure to those with mental illness, exposure from media, working with mentally ill people, to having a mental illness. The fear and dangerousness scale measured different items related to how much fear and dangerousness the participant associated with those who have mental illnesses on a Likert scale. The social distance scale had participants rate on a scale—of 0 to 3, with 3 being very willing—how likely they are to socialize in various ways with someone who has a mental illness. The results of this study found that those who are more familiar with mental illness, meaning more knowledge or experience, were less likely to believe that those with mental illness are dangerous. Those people, who believed that the mentally ill were less dangerous, were less likely to have fear towards the mentally ill, which also led to a decrease in desired social distance. Overall, people who reported more familiarity with mental illness, had less desired social distance from those with mental illness.

Angermeyer, Matschinger, and Corrigan (2004) set out to replicate the study done by Penn et al. (2001). They wanted to carry out the study using a population set that was more representative of the general population. They carried out the study in

Germany and had a total of 5,025 participants. They did not use exactly the same methodology as the Penn et al. study. Respondents were given vignettes that depicted someone who displayed schizophrenia or major depression. They were then given measures assessing familiarity, perceptions of dangerousness, fear, and the social distance scale. The results of this study, despite a slightly different methodology than the original study, were that those who expressed familiarity with mental illness expressed less desire for social distance. They also found a strong correlation between perceived dangerousness and social distance. Weaker perceptions of dangerousness corresponded to less fear with those who have mental illness, which in turn led to less desire for social distance. These two studies help illustrate that familiarity with mental illness, not just knowledge, can help lead to a lesser desire for social distance and, in turn, less stigmatization. This study helps replicate the results of the original study, but because the methods are slightly different it is not an exact replication. Moreover, because of its large sample size, the results are much more applicable to a general population.

Alexander and Link (2003) examined the impact of different kinds of contact on stigmatizing attitudes towards the mentally ill. They believed that while much of the data currently suggests that contact and familiarity with mental illness helps decrease stigmatization, that methodology regarding these findings could be improved upon. Their goal was to have a nationally representative sample that accurately reflected attitudes about mental illness and stigma. They measured contact with mental illness in four different ways: personal, impersonal, intentional, and unintentional. They used a

phone survey about the homeless and the homeless with mental illness from 1990, which included 1507 respondents and their attitudes. This included respondents' perceptions of their contact with the mentally ill and the degree to which they believed the mentally ill to be dangerous. They also used a subsample of 640 participants who looked at vignettes that depicted a character with mental illness, desire for social distance from that character, and perceived dangerousness of the character.

The results of this study confirmed that decreased perceptions of dangerousness and a lesser desire for social distance went hand-in-hand with increased contact with the mentally ill. Because it is more nationally representative and comprehensive than previous research, this study is an improvement on previous research. However, it does have some areas of concern. The first problem is that the participants from the original study and the subsample completed different measures. The other issue is that the data set that was collected in 1990 and, therefore, it is possible that attitudes may have changed by the time of publication in 2003.

Lauber et al. (2004) examined the different factors that can influence social distance within a population representative of Switzerland. Participants were given a vignette describing an individual with schizophrenia. They also completed questionnaires about social distance, attitudes/emotions towards those with mental illness, and attitudes towards the consequences of mental illness. They found overall that social distance is a multi-faceted issue. They found that social distance increased when there was an increase of implied closeness. This study also suggested that the

more knowledge participants had, particularly with schizophrenia, led to an increase for the desire in social distance. This study illustrates again that there is more to understanding mental illness and stigmatization than simply gaining knowledge. Knowledge about mental illness may in fact lead to more stigmatization. This study did not include the dangerousness aspect, which may have accounted for why participants wanted more social distance with increased knowledge. Indeed, they may have perceived more danger with schizophrenics with the gain in knowledge. Overall, this study helps showcase the different areas needed to understand social distance, but could have also included the dangerousness aspect to be more comprehensive.

van't Veer et al. (2006) did a comprehensive study on that public attitudes of the Dutch towards the mentally ill and how those attitudes influence their willingness to interact with the mentally ill. They used a questionnaire to assess these attitudes and had 812 participants. The attitudes examined included: demographics of the general public, stereotypes about mental patients, beliefs about the causes of mental illness, and how familiar they are with mental illness. The most significant finding of this study was how beliefs about the causes of mental illness affected the desire for social distance. The study found that respondents attributed the cause of mental illness as due to structural causes—out of a patient's control or genetic transmission, for example—had less desire for social distance. Respondents who attributed the cause of mental illness as due to individual factors—such as drug abuse—had a higher desire for increased social distance. Overall, this study helped illustrate how multifaceted public attitudes can be. This study incorporated an aspect that few previous studies

considered by examining the public opinions on the causes of mental illness and how these influence the desire for social distance. This aspect relates to understanding stereotypes of mental illness and how they can affect desire for social distance.

Overall, the data has shown that there is a link between personal experience with mental illness and desired amount of social distance. The literature, while extensive, could be further examined to include how knowing someone with mental illness, and the extent of how close the relationship is, can affect the amount of social distance desired. The goal of this project is to use a nationally representative sample set to examine how familiarity plays a role in determining the desired amount of social distance. Previous research has not examined a nationally representative survey that looks at the proximity of someone who has mental illness and desire for social distance in a more current timeframe. The goal is to help better understand what affects stigmatization of the mentally ill.

Methodology

While previous research has attempted to make links between knowledge of mental illness and desire for stigmatization, research has shown that researchers should not automatically assume that knowledge about a topic will always lead to a perfect predictor of behavioral responses (Ajzen and Fishnein 1980; Struch and Schwartz 1989; Krauss 1995). Having knowledge about mental illness or the mentally ill will not always result in a lesser desire for social distance and decreased stigmatization. Taking previous research into account, this research is not focusing on how much knowledge the participants have about mental illness, but rather about how close they are to someone who has a mental illness. Previous research by Link and Cullen (1986) has shown that contact with the mentally ill, voluntary or involuntary, can influence perceptions of the mentally ill, which can lower the desire for social distance.

In order to have a study that is more representative of the general public, the General Social Survey (GSS) is being used. Previous research has shown the merits of utilizing the large, representative samples found in the GSS (Link et. al 1999b; Phelan et. al 2002; Martin et. al 2002). While convenience samples of undergraduate populations can be large, they are not fundamentally representative of either the age or socioeconomic standings of the population at large.

The data used in this study is drawn from the GSS administered by the National Opinion Research Center (NORC). The GSS is a nationally representative survey, conducted by face-to-face interviews that lasted about 90 minutes, of non-

institutionalized adults living in the United States. The 1996 and 2006, GSS included a special health topical module, the MacArthur Mental Health Module, which looked at several different mental health issues. The 2006 special health topic module was focused on mental health and social networks. In 2006, two changes were made to the GSS. First, Spanish interviews were conducted. The target population was adults living in American households who speak English or Spanish. Second, a third sample was added to accommodate more supplements. This led to a total sample size of 4,510 in 2006. The mental health module was randomly administered to the sample size of 4,510 participants (See Davis and Smith [2006] for a complete discussion of sampling and methodologies). There were between 958 – 933 (21%) participants who answered questions on the mental health module out of the 4,510 participants that took the GSS in 2006. Using these mental health questions from the GSS can help further examine the relationship between proximity to those who have mental illness and the corresponding amount of desired social distance. The GSS also provides information on the gender, race, and the socioeconomic status of the participants.

The dependent variable, preference for social distance, is measured by responses to five social distance items. The respondents were asked to indicate how willing they would be to: (1) “R would spend time socializing with X”, (2) “R would have X as a neighbor”, (3) “R would have X care for your children”, (4) “R would work closely with X on a job”, and (5) “R would have X marry someone related to you”. In the questions, R stands for Respondent and X stands for person with mental illness. Responses of “definitely willing”, “probably willing”, “probably unwilling”, and

“definitely unwilling” were coded 1 to 4, respectively, and combined to produce a summative scale of preferences for social distance from people with mental health problems that ranged from a 5, which is low social distance/stigmatization, to 20, which is high desire for social distance and stigmatization. These items were picked as they are similar to the Bogardus Social Distance Scale. Bogardus’s original scale had seven items that asked the extent to which the respondent would be willing to accept members of a group: close relatives by marriage, close personal friend, neighbors on the same street, co-workers in the same occupation, citizens in my country, as only visitors in my country, and would exclude from my country (Bogardus, 1933). The questions taken from the GSS are as closely representative to the Bogardus Social Distance Scale as possible. The objective of the variables used in this study is to examine the extent of social interaction the respondent would have with a person with a mental disorder in varying degrees of personal contact.

The independent variable is how close the respondents are to someone with a mental health problem. This is measured by 4 different responses: “extremely close”, “very close”, “not very close” and “not close at all”. The responses were coded 1 to 4 respectively.

Gender, age and race are the moderating variables of this study. Age is measured in years and is recoded in three groups: Young- 18-35, Middle- 36-55, and Older- 56 and up. For gender, men = 1 and women =2. Race is divided into three groups: 1= whites, 2 = Blacks and 3= others.

Previous research indicates that an older, less tolerant generation is being gradually being replaced in America. Studies demonstrate that the younger generation is more tolerant and possesses lower levels of prejudice (Firebaugh and Davis 1988; Bobo, Kluegel and Smith 1997). The pattern present in previous research suggests that there is a positive trend in attitudes towards all outgroups members. "Younger groups, by virtue of their contact with a progressive educational institution have acquired more tolerant attitudes toward socially and culturally diverse groups" (Martin et. al 2000:212). In relation to mental health, research has shown support for the idea that acceptance of those with mental health is inversely related to age (Whatley 1958: Crocetti and Lemkau 1963; Phillips 1963). The results of these studies emphasize that the older, prejudiced generation is being replaced with a younger, more liberal cohort, which can lead to less stigmatization. In a similar approach, those who have personally experienced prejudice (i.e., African Americans, and women) should also be less likely to have negative attitudes towards outgroups members (Martin et. al 2000).

Hypotheses

Based upon above research, there are with several hypotheses for this study:

1. The closer the relationship to a person with mental illness, the lesser the desire of social distance.
2. The younger the participant, the lesser desire for social distance.
3. Women will have a lesser desire for social distance than men.
4. Non-white participants will have a lesser desire for social distance than whites.

Analysis

Descriptive analysis is used to test the research hypotheses outlined above. These descriptive analyses are used to assess respondents' desires to avoid, or not avoid, social interactions with people suffering from mental illness. Crosstabulations were used to produce a general contingency table, which displays how closeness to a person with a mental health problem was interrelated with different levels of social distance.

Chi square tests were run for each of the five dependent variables to examine correlations and to determine if there were a significant deviation between the variables' relationship beyond chance. Chi square tests were again run with each of the moderating variables: gender, age, and race. Gamma symmetric measures were also run for each of the five dependent variables' relationship with closeness to a person with a mental health problem and again with each moderating variable to further examine the strength of the relationship between variables. In the analysis, significant approximate gamma levels can be assumed due to the large sample size of the GSS. All analyses were run through the statistical program SPSS version 12.0.

Results

Characteristics of Sample

Respondents Gender (Table 1.0)

	Frequency	Percent
MALE	2003	44.4
FEMALE	2507	55.6
Total	4510	100.0

Respondents Race (Table 1.2)

	Frequency	Percent
WHITE	3284	72.8
BLACK	634	14.1
OTHER	592	13.1
Total	4510	100.0

Respondents Age (Table 1.3)

	Frequency	Percent
18-28	687	15.2
29-39	969	21.5
40-50	1061	23.5
51-61	842	18.7
62-72	527	11.7
73-83	307	6.8
84 +	117	2.6
Total	4510	100.0

Tables 1.0-1.3 reflect the distribution of gender, race, and age of all the respondents of the 2006 GSS. This was done in order to examine the respondents. Table 1.0 demonstrates that there are more female participants than males, 55.6%. Table 1.2 shows that a majority of respondents identified themselves as White (73.8%). Respondents who identified as being Black (14.1%) or other (13.1%) racial category are similar in numbers. Table 1.3 shows that the largest number of respondents is between ages 29-50 (45%). The next largest age group is 51-61 (18.7 %).

Hypothesis #1—the closer someone is to a person with a mental illness, the less likely they are to desire social distance—will be examined by looking individually at each dependent variables relationship with the independent variable:

**Respondent would spend time socializing with a person
With a mental health problem and
Closeness to person with mental health problem (Table 2.0)**

Respondent would spend time socializing with a person with a mental health problem	Closeness to Person with Mental Health Problem				Total
	Extremely close	Very close	Not very close	Not at all close	
Definitely willing	114 35.7%	101 26.6%	39 19.4%	15 25.4%	269 28.1%
Probably willing	141 44.2%	193 50.9%	108 53.7%	27 45.8%	469 49.0%
Probably unwilling	52 16.3%	69 18.2%	44 21.9%	16 27.1%	181 18.9%
Definitely unwilling	12 3.8%	16 4.2%	10 5.0%	1 1.7%	39 4.1%
Total	319 100.0%	379 100.0%	201 100.0%	59 100.0%	958 100.0%

($\chi^2 = 20.922$, $df = 9$, $p < 0.05$) (Gamma = .156 p .000)

The results from table 2.0 demonstrate that there is a relationship between how close one is to a person with a mental illness and how likely one is to want to socialize with a mentally ill person. Chi square of 20.922 with 9 degrees of freedom indicates the probability value is .013. That is less than .05 and thus can be considered significant, i.e., the relationship found in this table is not likely to be a product of chance. The closeness influences willingness to spend time socializing. Gamma indicates a weak relationship.

Most respondents said they were either extremely close (33.3 %) or very close (39.5%) with someone who has a mental illness. Out of those who identified as being extremely close with someone with a mental illness, 79.9% were either definitely or probably willing to socialize with someone who has a mental illness. Out of those who identified as being very close to someone with a mental illness, 77.5 % were either definitely or probably willing to socialize with someone who has a mental illness.

**Respondent would work closely with a
Person with a mental health problem on a job and
Closeness to person with mental health problem (Table 2.1)**

Respondent would work closely with a person with a mental health problem on a job	Closeness to Person with Mental Health Problem				Total
	Extremely close	Very close	Not very close	Not at all close	
Definitely willing	81 25.6%	81 21.5%	43 21.2%	7 11.9%	212 22.2%
Probably willing	140 44.3%	162 43.0%	78 38.4%	32 54.2%	412 43.1%
Probably unwilling	67 21.2%	100 26.5%	56 27.6%	16 27.1%	239 25.0%
Definitely unwilling	28 8.9%	34 9.0%	26 12.8%	4 6.8%	92 9.6%
Total	316 100.0%	377 100.0%	203 100.0%	59 100.0%	955 100.0%

($\chi^2 = 13.316$, $df = 9$, $p > 0.05$) (Gamma = .100 p .012)

The results from table 2.1 demonstrate that there is not a statistically significant relationship between how close one is to a person with a mental illness and how likely one is to want to work closely with someone who has a mental illness. Chi square of 13.316 with 9 degrees of freedom indicates the probability value is .149. That is more than .05 and, thus, cannot be considered significant, i.e., the relationship found in this table is likely to be a product of chance. Gamma indicates a weak relationship, even though there is an approximate significance of gamma of .012.

**Respondent would have a person with a mental health problem as a neighbor and
Closeness to person with mental health problem (Table 2.2)**

Respondent would have a person with a mental health problem as a neighbor	Closeness to Person with Mental Health Problem				Total
	Extremely close	Very close	Not very close	Not at all close	
Definitely willing	134 42.1%	132 35.1%	62 30.7%	23 39.0%	351 36.8%
Probably willing	146 45.9%	186 49.5%	104 51.5%	27 45.8%	463 48.5%
Probably unwilling	30 9.4%	48 12.8%	28 13.9%	6 10.2%	112 11.7%
Definitely unwilling	8 2.5%	10 2.7%	8 4.0%	3 5.1%	29 3.0%
Total	318 100.0%	376 100.0%	202 100.0%	59 100.0%	955 100.0%

($\chi^2 = 10.381$, $df = 9$, $p > 0.05$) (Gamma = .113 $p .010$)

The results from table 2.2 demonstrate that there is not a statistically significant relationship between how close one is to a person with a mental illness and how likely one is to want to have someone who has a mental illness for a neighbor. Chi square of 10.381 with 9 degrees of freedom indicates the probability value is .321. That is more than .05 and, thus, cannot be considered significant, i.e., the relationship found in this table is likely to be a product of chance. Gamma indicates a weak relationship .113,

even though there is an approximate significance of gamma of .010.

**Respondent would have person with a
Mental health problem care for your children and
Closeness to person with mental health problem (Table 2.3)**

	Respondent would have a person with a mental health problem care for your children	Closeness to Person with Mental Health Problem				Total
		Extremely close	Very close	Not very close	Not at all close	
	Definitely willing	29 9.1%	16 4.3%	9 4.5%	3 5.1%	57 6.0%
	Probably willing	54 16.9%	59 15.9%	31 15.5%	5 8.5%	149 15.7%
	Probably unwilling	94 29.5%	121 32.6%	62 31.0%	17 28.8%	294 31.0%
	Definitely unwilling	142 44.5%	175 47.2%	98 49.0%	34 57.6%	449 47.3%
	Total	319 100.0%	371 100.0%	200 100.0%	59 100.0%	949 100.0%

($\chi^2 = 12.569$, $df = 9$, $p > 0.05$) (Gamma = .097 $p = .024$)

The results from table 2.3, show that there is not a statistically significant relationship between how close one is to a person with a mental illness and how likely one is to want to have someone who has a mental illness care for your child. Chi square of 12.569 with 9 degrees of freedom indicates the probability value is .183. That is more than .05 and, thus, cannot be considered significant, i.e., the relationship found in this table is likely to be a product of chance. Gamma indicates a weaker relationship .097,

the approximate significance of gamma is .024

**Respondent would have person with a
Mental health problem marry someone related to them by
Closeness to person with mental health problem (Table 2.4)**

Respondent would have a person with a mental health problem marry someone related to them	Closeness to Person with Mental Health Problem				Total
	Extremely close	Very close	Not very close	Not at all close	
Definitely willing	55 17.6%	29 8.0%	18 9.1%	7 11.9%	109 11.7%
Probably willing	104 33.3%	125 34.3%	69 34.8%	17 28.8%	315 33.8%
Probably unwilling	82 26.3%	122 33.5%	62 31.3%	21 35.6%	287 30.8%
Definitely unwilling	71 22.8%	88 24.2%	49 24.7%	14 23.7%	222 23.8%
Total	312 100.0%	364 100.0%	198 100.0%	59 100.0%	933 100.0%

($\chi^2 = 19.072$, $df = 9$, $p < 0.05$) (Gamma = .087 $p = .033$)

The results from table 2.4 demonstrate that there is a relationship between how close one is to a person with a mental illness and how likely one is to want to want a person with a mental illness to marry a family member. Chi square of 19.072 with 9 degrees of freedom indicates the probability value is .025. That is less than .05 and, thus, can be considered significant, i.e., the relationship found in this table is not likely

to be a product of chance. The closeness influences willingness to have someone with a mental illness marry a family member. Gamma indicates a strong relationship with the value of .041 and approximate significance of .033.

Hypothesis #2—the younger a participant is the lesser the desire for social distance—will be examined by looking individually at each dependent variables' relationship with the independent variable:

**Willingness to spend Time Socializing with a Person with a Mental Health Problem and Closeness to Person with Mental Health Problem Age of Respondents
(Table 3.0)**

Age of Respondents	Respondent Would Spend Time Socializing with a Person with Mental Health Problem	Closeness to Person with Mental Health Problem				Total
		Extremely close	Very close	Not very close	Not at all close	
Young 18 - 35	Definitely willing	43 45.3%	28 28.3%	13 26.0%	5 38.5%	89 34.6%
	Probably willing	36 37.9%	48 48.5%	28 56.0%	7 53.8%	119 46.3%
	Probably unwilling	11 11.6%	21 21.2%	7 14.0%	1 7.7%	40 15.6%
	Definitely unwilling	5 5.3%	2 2.0%	2 4.0%	0 .0%	9 3.5%
Middle 36 - 55	Definitely willing	43 28.9%	41 25.6%	17 20.0%	4 16.0%	105 25.1%
	Probably willing	76 51.0%	85 53.1%	43 50.6%	10 40.0%	214 51.1%
	Probably unwilling	27 18.1%	24 15.0%	22 25.9%	11 44.0%	84 20.0%
	Definitely unwilling	3 2.0%	10 6.3%	3 3.5%	0 .0%	16 3.8%
Older 56 +	Definitely willing	28 37.3%	32 26.7%	9 13.6%	6 28.6%	75 26.6%
	Probably willing	29 38.7%	60 50.0%	37 56.1%	10 47.6%	136 48.2%
	Probably unwilling	14 18.7%	24 20.0%	15 22.7%	4 19.0%	57 20.2%
	Definitely unwilling	4 5.3%	4 3.3%	5 7.6%	1 4.8%	14 5.0%

For 18 - 35 ($\chi^2 = 13.659$, $df = 9$, $p > 0.05$) (Gamma = .134 p .106)
 For 36 - 55 ($\chi^2 = 18.931$ $df = 9$, $p < 0.05$) (Gamma = .161 p .012)
 For 56 + ($\chi^2 = 11.675$, $df = 9$, $p > 0.05$) (Gamma = .159 p .044)

The results from table 3.0 demonstrate that there is a relationship between how close one is to a person with a mental illness and how likely one is to want to socialize with a mentally ill person, with the middle age group (36-55) as a mediating variable. Chi square of 18.931 with 9 degrees of freedom indicates the probability value is .026. That is less than .05 and, thus, can be considered significant, i.e., the relationship found in this table is not likely to be a product of chance. Gamma indicates a weak relationship with the value of .161, even though there is an approximate significance of gamma of .012.

Results from figure 3.0 demonstrate that there is no statistical significance for the young category (ages 18-35) with a Chi square of 14.845. 9 degrees of freedom indicates that the probability value is .135, which is less than .05 and cannot be considered significant. The gamma value of .134 indicates a weak relationship and a low approximate significance level of .106.

Results demonstrate that there is no statistical significance for the older category (ages 53 and up) with a chi square of 11.675 and 9 degrees of freedom indicates that the probability value is .232, which is less than .05 and cannot be considered significant. The gamma value of .159 indicates a weak relationship, even though there is an approximate significance of gamma of .044. This is most likely from the large sample size.

**Respondent Would Work Closely with Person with a Mental Health Problem on a Job
and Closeness to Person with Mental Health Problem and Age of Respondents
(Table 3.1)**

Age of Respondents	Respondent Would Work Closely with a Person with Mental Health Problems on a Job	Closeness to Person with Mental Health Problem				Total
		Extremely close	Very close	Not very close	Not at all close	
Young 18 - 35	Definitely willing	29	25	13	2	69
		31.2%	25.0%	25.5%	15.4%	26.8%
	Probably willing	41	40	18	8	107
		44.1%	40.0%	35.3%	61.5%	41.6%
	Probably unwilling	15	28	16	3	62
	16.1%	28.0%	31.4%	23.1%	24.1%	
	Definitely unwilling	8	7	4	0	19
		8.6%	7.0%	7.8%	.0%	7.4%
Middle 36 - 55	Definitely willing	34	31	18	3	86
		22.8%	19.6%	20.9%	11.5%	20.5%
	Probably willing	74	72	33	13	192
		49.7%	45.6%	38.4%	50.0%	45.8%
	Probably unwilling	31	40	26	9	106
	20.8%	25.3%	30.2%	34.6%	25.3%	
	Definitely unwilling	10	15	9	1	35
		6.7%	9.5%	10.5%	3.8%	8.4%
Older 56 +	Definitely willing	18	25	12	2	57
		24.3%	21.0%	18.2%	10.0%	20.4%
	Probably willing	25	50	27	11	113
		33.8%	42.0%	40.9%	55.0%	40.5%
	Probably unwilling	21	32	14	4	71
	28.4%	26.9%	21.2%	20.0%	25.4%	
	Definitely unwilling	10	12	13	3	38
		13.5%	10.1%	19.7%	15.0%	13.6%

For 18 - 35 ($\chi^2 = 8.761$, $df = 9$, $p > 0.05$) (Gamma = .111 p .147)

For 36 - 55 ($\chi^2 = 7.825$ $df = 9$, $p > 0.05$) (Gamma = .171 p .053)

For 56 + ($\chi^2 = 7.686$, $df = 9$, $p > 0.05$) (Gamma = .048 p .520)

The results from table 3.1 demonstrate that statistical significance was not reached for any of the age groups when looking at how close a respondent is to someone with a mental illness and how likely he/she is to want to work closely with someone who has a mental illness. Chi square for the young group, with 8.761 and 9 degrees of freedom indicates that the probability level is .460. The gamma value is .111, which indicates a weak relationship level with an approximate significance level of .147. chi square for the middle age group, with 7.825 and 9 degrees of freedom, indicates that the probability level is .552. The gamma value for the middle age group is .117, which indicates a weak relationship. The approximate significance level is .053, which is close to significant, but this can be due to the large sample size. The chi square for the older age group, with 7.868 and 9 degrees for freedom, indicates that the probability level is .566. The gamma level for the older age group is .048, which indicates a stronger relationship, but the approximate significance level is .520.

Respondent Would Have a Person with Mental Health Problems as a Neighbor and Closeness to Person with Mental Health Problem and Age of Respondents (Table 3.2)

Age of Respondents	Respondent Would Have a Person with Mental Health Problems as a Neighbor	Closeness to Person with Mental Health Problem				Total
		Extremely close	Very close	Not very close	Not at all close	
Young 18 - 35	Definitely willing	47	35	15	6	103
		50.0%	35.4%	29.4%	46.2%	40.1%
	Probably willing	38	48	28	7	121
		40.4%	48.5%	54.9%	53.8%	47.1%
	Probably unwilling	5	13	6	0	24
	5.3%	13.1%	11.8%	.0%	9.3%	
	Definitely unwilling	4	3	2	0	9
		4.3%	3.0%	3.9%	.0%	3.5%
Middle 36 - 55	Definitely willing	59	50	27	7	143
		39.3%	31.6%	31.4%	26.9%	34.0%
	Probably willing	74	85	46	14	219
		49.3%	53.8%	53.5%	53.8%	52.1%
	Probably unwilling	14	17	12	4	47
	9.3%	10.8%	14.0%	15.4%	11.2%	
	Definitely unwilling	3	6	1	1	11
		2.0%	3.8%	1.2%	3.8%	2.6%
Older 56 +	Definitely willing	28	47	20	10	105
		37.8%	39.5%	30.8%	50.0%	37.8%
	Probably willing	34	53	30	6	123
		45.9%	44.5%	46.2%	30.0%	44.2%
	Probably unwilling	11	18	10	2	41
	14.9%	15.1%	15.4%	10.0%	14.7%	
	Definitely unwilling	1	1	5	2	9
		1.4%	.8%	7.7%	10.0%	3.2%

For 18 - 35 ($\chi^2 = 11.525$, $df = 9$, $p > 0.05$) (Gamma = .171 p .041)

For 36 - 55 ($\chi^2 = 5.805$, $df = 9$, $p > 0.05$) (Gamma = .121 p .073)

For 56 + ($\chi^2 = 12.822$, $df = 9$, $p > 0.05$) (Gamma = .056 p .496)

Results from table 3.2 demonstrate that there is no statistical significance found within any of the age groups when looking at how close a respondent is to

someone with a mental health problem. Table 3.2 also indicates there is no relationship between age and how likely one is to want to work closely with the mentally ill. Chi square for the young group, with 11.525 and 9 degrees of freedom, indicates that the probability level is .241. The gamma value is .084, which indicates a weak relationship level with an approximate significance level of .041. This significance can be attributed to the large sample size. Chi square for the middle age group, with 5.805 and 9 degrees of freedom, indicates that the probability level is .789. The gamma value for the middle age group is .121, which indicates a weak relationship; the approximate significance level is .073. The chi square for the older age group, with 11.946 and 9 degrees of freedom, indicates that the probability level is .171. The gamma level for the older age group is .081, which indicates a weak relationship. The approximate significance level is .496.

Respondent Would Have a Person with Mental Health Problems Care for Their Children and Closeness to Person with Mental Health Problem and Age of Respondents (Table 3.3)

Age of Respondents	Respondent Would Have a Person with Mental Health Problem Care for Their Children	Closeness to Person with Mental Health Problem				Total
		Extremely close	Very close	Not very close	Not at all close	
Young 18 - 35	Definitely willing	8 8.4%	3 3.1%	2 4.0%	0 .0%	13 5.1%
	Probably willing	15 15.8%	18 18.4%	10 20.0%	0 .0%	43 16.8%
	Probably unwilling	28 29.5%	32 32.7%	16 32.0%	4 30.8%	80 31.3%
	Definitely unwilling	44 46.3%	45 45.9%	22 44.0%	9 69.2%	120 46.9%
Middle 36 - 55	Definitely willing	12 7.9%	6 3.8%	5 6.0%	1 3.8%	24 5.8%
	Probably willing	26 17.2%	20 12.8%	11 13.1%	4 15.4%	61 14.6%
	Probably unwilling	48 31.8%	57 36.5%	23 27.4%	7 26.9%	135 32.4%
	Definitely unwilling	65 43.0%	73 46.8%	45 53.6%	14 53.8%	197 47.2%
Older 56 +	Definitely willing	9 12.3%	7 6.0%	2 3.0%	2 10.0%	20 7.2%
	Probably willing	13 17.8%	21 17.9%	10 15.2%	1 5.0%	45 16.3%
	Probably unwilling	18 24.7%	32 27.4%	23 34.8%	6 30.0%	79 28.6%
	Definitely unwilling	33 45.2%	57 48.7%	31 47.0%	11 55.0%	132 47.8%

For 18 - 35 ($\chi^2 = 8.008$, $df = 9$, $p > 0.05$) (Gamma = .070 p .401)

For 36 - 55 ($\chi^2 = 6.864$ $df = 9$, $p > 0.05$) (Gamma = .118 p .075)

For 56 + ($\chi^2 = 8.329$, $df = 9$, $p > 0.05$) (Gamma = .079 p .217)

Results from table 3.3 demonstrates that there is no statistical significance with any age groups when looking at how close a respondent is to someone with a mental health problem and how likely one is to want a mentally ill person to care for his/her children. Chi square for the young group, with 8.008 and 9 degrees of freedom, indicates that the probability level is .533. The gamma value is .070, which indicates a weak relationship level with an approximate significance level of .401. Chi square for the middle age group, with 6.864 and 9 degrees of freedom, indicates that the probability level is .651. The gamma value for the middle age group is .118, which indicates a weak relationship. The approximate significance level is .075. The chi square for the older age group, with 8.329 and 9 degrees for freedom, indicates that the probability level is .501. The gamma level for the older age group is .097, which indicates a weak relationship. The approximate significance level is .217.

Respondent Would have a Person with Mental Health Problems Marry Someone Related to Them and Closeness to Person with Mental Health Problem and Age of Respondents (Table 3.4)

Age of Respondents	Respondent Would have a Person with Mental Health Problem Marry Someone Related to You	Closeness to Person with Mental Health Problem				Total
		Extremely close	Very close	Not very close	Not at all close	
Young 18 - 35	Definitely willing	23 24.2%	9 9.3%	6 12.5%	1 8.3%	39 15.5%
	Probably willing	37 38.9%	37 38.1%	21 43.8%	6 50.0%	101 40.1%
	Probably unwilling	18 18.9%	32 33.0%	11 22.9%	3 25.0%	64 25.4%
	Definitely unwilling	17 17.9%	19 19.6%	10 20.8%	2 16.7%	48 19.0%
Middle 36 - 55	Definitely willing	23 15.8%	12 7.9%	8 9.3%	3 11.5%	46 11.2%
	Probably willing	48 32.9%	50 33.1%	29 33.7%	7 26.9%	134 32.8%
	Probably unwilling	47 32.2%	53 35.1%	29 33.7%	10 38.5%	139 34.0%
	Definitely unwilling	28 19.2%	36 23.8%	20 23.3%	6 23.1%	90 22.0%
Older 56 +	Definitely willing	9 12.7%	8 6.9%	4 6.3%	3 14.3%	24 8.8%
	Probably willing	19 26.8%	38 32.8%	19 29.7%	4 19.0%	80 29.4%
	Probably unwilling	17 23.9%	37 31.9%	22 34.4%	8 38.1%	84 30.9%
	Definitely unwilling	26 36.6%	33 28.4%	19 29.7%	6 28.6%	84 30.9%

For 18 - 35 ($\chi^2 = 12.410$, $df = 9$, $p > 0.05$) (Gamma = .133 p .096)

For 36 - 55 ($\chi^2 = 5.875$, $df = 9$, $p > 0.05$) (Gamma = .090 p .140)

For 56 + ($\chi^2 = 7.012$, $df = 9$, $p > 0.05$) (Gamma = .000 p .998)

Results from table 3.4 demonstrate that there is no statistical significance with any age groups when looking at how close a respondent is to someone with a mental health problem and how likely he/she is to have a person with a mental health problem

marry someone in his/her family. Chi square for the young group, with 12.401 and 9 degrees of freedom, indicates that the probability level is .191. The gamma value is .133, which indicates a weak relationship level with an approximate significance level of .096. Chi square for the middle age group, with 5.875 and 9 degrees of freedom, indicates that the probability level is .752. The gamma value for the middle age group is .090, which indicates a weak relationship. The approximate significance level is .140. The chi square for the older age group, with 7.050 and 9 degrees for freedom, indicates that the probability level is .632. The gamma level for the older age group is .000, which indicates strong relationship, but the approximate significance level is .998.

Hypothesis #3—women will have a lesser desire for social distance than men—will be examined by looking individually at each dependent variables' relationship with the independent variable:

Respondent Would Spend Time Socializing with a Person with Mental Health Problems and Closeness to Person with Mental Health Problem and Respondents Gender (Table 4.0)

Gender	Respondent Would Spend Time Socializing with a Person with Mental Health Problem	Closeness to Person with Mental Health Problem				Total
		Extremely close	Very close	Not very close	Not at all close	
Male	Definitely willing	35 30.4%	41 22.7%	18 17.6%	6 20.0%	100 23.4%
	Probably willing	54 47.0%	97 53.6%	53 52.0%	12 40.0%	216 50.5%
	Probably unwilling	21 18.3%	33 18.2%	25 24.5%	11 36.7%	90 21.0%
	Definitely unwilling	5 4.3%	10 5.5%	6 5.9%	1 3.3%	22 5.1%
Female	Definitely willing	79 38.7%	60 30.3%	21 21.2%	9 31.0%	169 31.9%
	Probably willing	87 42.6%	96 48.5%	55 55.6%	15 51.7%	253 47.7%
	Probably unwilling	31 15.2%	36 18.2%	19 19.2%	5 17.2%	91 17.2%
	Definitely unwilling	7 3.4%	6 3.0%	4 4.0%	0 .0%	17 3.2%

For Males ($\chi^2 = 11.061$, $df = 9$, $p > 0.05$) (Gamma = .156 p .015)

For Females ($\chi^2 = 11.199$, $df = 9$, $p > 0.05$) (Gamma = .135 p .019)

Results from table 4.0 demonstrate that there is no statistical significance between males and females when looking at how close a respondent is to someone with a mental health problem and how likely he/she is to want to socialize with a mentally ill person. Chi square for males, with 11.061 and 9 degrees of freedom, indicates that the probability level is .272. The gamma value is .157, which indicates a weak relationship level with an approximate significance level of .015, which can be due to the large sample size. Chi square for females group, with 11.199 and 9 degrees of freedom, indicates that the probability level is .262. The gamma value for women is .135, which indicates a weak relationship. The approximate significance level is .019.

**Respondent Would Work Closely with a Person with a Mental Health Problem
on a Job and Closeness to Person with Mental Health Problem and Respondents
Gender (Table 4.1)**

Gender	Respondent Would Work Closely with Person with Mental Health Problem on a Job	Closeness to Person with Mental Health Problem				Total
		Extremely close	Very close	Not very close	Not at all close	
MALE	Definitely willing	25	40	20	4	89
		21.9%	22.1%	19.6%	12.9%	20.8%
	Probably willing	55	84	0	16	195
		48.2%	46.4%	39.2%	51.6%	45.6%
	Probably unwilling	23	41	29	9	102
		20.2%	22.7%	28.4%	29.0%	23.8%
	Definitely unwilling	11	16	13	2	42
		9.6%	8.8%	12.7%	6.5%	9.8%
FEMALE	Definitely willing	56	41	23	3	123
		27.7%	20.9%	22.8%	10.7%	23.3%
	Probably willing	85	78	38	16	217
		42.1%	39.8%	37.6%	57.1%	41.2%
	Probably unwilling	44	59	27	7	137
		21.8%	30.1%	26.7%	25.0%	26.0%
	Definitely unwilling	17	18	13	2	50
		8.4%	9.2%	12.9%	7.1%	9.5%

For Males ($\chi^2 = 6.007$, $df = 9$, $p > 0.05$) (Gamma = .089 p .134)

For Females ($\chi^2 = 10.582$, $df = 9$, $p > 0.05$) (Gamma = .112 p .038)

Results from table 4.1 demonstrate that there is no statistical significance between males and females when looking at how close a respondent is to someone with

a mental health problem and how likely he/she is to want to socialize with a mentally ill person. Chi square for males, with 6.007 and 9 degrees of freedom, indicates that the probability level is .739. The gamma value is .089, which indicates a weak relationship level with an approximate significance level of .134. Chi square for females group, with 10.589 and 9 degrees of freedom, indicates that the probability level is .309. The gamma value for women is .112 which indicates a weak relationship. The approximate significance level is .038.

Respondent Would Have a Person with a Mental Health Problem as a Neighbor and Closeness to Person with Mental Health Problem and Respondents Gender (Table 4.2)

Gender	Respondent Would Have a Person with a Mental Health Problem as a Neighbor	Closeness to Person with Mental Health Problem				Total
		Extremely close	Very close	Not very close	Not at all close	
MALE	Definitely willing	41 35.7%	56 31.3%	29 28.4%	7 22.6%	133 31.1%
	Probably willing	54 47.0%	92 51.4%	49 48.0%	18 58.1%	213 49.9%
	Probably unwilling	16 13.9%	26 14.5%	19 18.6%	3 9.7%	64 15.0%
	Definitely unwilling	4 3.5%	5 2.8%	5 4.9%	3 9.7%	17 4.0%
FEMALE	Definitely willing	93 45.8%	76 38.6%	33 33.0%	16 57.1%	218 41.3%
	Probably willing	92 45.3%	94 47.7%	55 55.0%	9 32.1%	250 47.3%
	Probably unwilling	14 6.9%	22 11.2%	9 9.0%	3 10.7%	48 9.1%
	Definitely unwilling	4 2.0%	5 2.5%	3 3.0%	0 .0%	12 2.3%

For Males ($\chi^2 = 7.538$, $df = 9$, $p > 0.05$) (Gamma = .106 p .101)

For Females ($\chi^2 = 10.615$, $df = 9$, $p > 0.05$) (Gamma = .089 p .146)

Results from table 4.2 demonstrate that there is no statistical significance between males and females when looking at how close a respondent is to someone with

a mental health problem and how likely he/she is to want to have someone with a mental health problem be his/her neighbor. Chi square for males, with 7.358 and 9 degrees of freedom, indicates that the probability level is .581. The gamma value is .106, which indicates a weak relationship level with an approximate significance level of .101. Chi square for females group, with 10.615 and 9 degrees of freedom, indicates that the probability level is .303. The gamma value for women is .089, which indicates a weak relationship. The approximate significance level is .146.

Respondent Would have a Person with Mental Health Problem Care for Their Child and Closeness to Person with Mental Health Problem and the Respondents Gender (Table 4.3)

Gender	Respondent Would Have a Person with Mental Health Problem Care for Their Children	Closeness to Person with Mental Health Problem				Total
		Extremely close	Very close	Not very close	Not at all close	
MALE	Definitely willing	9	9	3	3	24
		7.9%	5.0%	3.0%	9.7%	5.6%
	Probably willing	19	33	15	2	69
		16.7%	18.3%	14.9%	6.5%	16.2%
	Probably unwilling	37	54	34	9	134
32.5%		30.0%	33.7%	29.0%	31.5%	
Definitely unwilling	49	84	49	17	199	
		43.0%	46.7%	48.5%	54.8%	46.7%
FEMALE	Definitely willing	20	7	6	0	33
		9.8%	3.7%	6.1%	.0%	6.3%
	Probably willing	35	26	16	3	80
		17.1%	13.6%	16.2%	10.7%	15.3%
	Probably unwilling	57	67	28	8	160
27.8%		35.1%	28.3%	28.6%	30.6%	
Definitely unwilling	93	91	49	17	250	
		45.4%	47.6%	49.5%	60.7%	47.8%

For Males ($\chi^2 = 7.008$, $df = 9$, $p > 0.05$) (Gamma = .092 p .143)

For Females ($\chi^2 = 12.241$, $df = 9$, $p > 0.05$) (Gamma = .107 p .072)

Results from table 4.3 demonstrate that there is no significance for either males or females when looking at how close a respondent is to someone with a mental health problem and how likely he/she is to want to have someone with a mental health problem watch his/her child. Chi square for males, with 7.008 and 9 degrees of freedom, indicates that the probability level is .636. The gamma value is .091, which indicates a weak relationship level with an approximate significance level of .143. Chi square for female group, with 12.241 and 9 degrees of freedom, indicates that the probability level is .200. The gamma value for women is .107 which indicates a weak relationship. The approximate significance level is .072.

Respondent Would have a Person with a Mental Health Problem Marry Someone Related to Them and Closeness to Person with Mental Health Problem and Respondents Gender (Table 4.4)

Gender	Respondent Would have a Person with Mental Health Problem Marry Someone Related to You	Closeness to Person with Mental Health Problem				Total
		Extremely close	Very close	Not very close	Not at all close	
MALE	Definitely willing	21	15	7	4	47
		18.4%	8.5%	7.0%	12.9%	11.1%
	Probably willing	38	63	40	7	148
		33.3%	35.6%	40.0%	22.6%	35.1%
	Probably unwilling	34	58	27	12	131
		29.8%	32.8%	27.0%	38.7%	31.0%
	Definitely unwilling	21	41	26	8	96
		18.4%	23.2%	26.0%	25.8%	22.7%
FEMALE	Definitely willing	34	14	11	3	62
		17.2%	7.5%	11.2%	10.7%	12.1%
	Probably willing	66	62	29	10	167
		33.3%	33.2%	29.6%	35.7%	32.7%
	Probably unwilling	48	64	35	9	156
		24.2%	34.2%	35.7%	32.1%	30.5%
	Definitely unwilling	50	47	23	6	126
		25.3%	25.1%	23.5%	21.4%	24.7%

For Males ($\chi^2 = 13.246$, $df = 9$, $p > 0.05$) (Gamma = .113 p .062)

For Females ($\chi^2 = 12.494$, $df = 9$, $p > 0.05$) (Gamma = .072 p .198)

Results from table 4.4 demonstrate that there is no statistical significance for either males or females when looking at how close a respondent is to someone with a mental health problem and how likely he/she is to want to have someone with a mental health problem marry someone in the respondent's family. Chi square for males, with 13.246 and 9 degrees of freedom, indicates that the probability level is .152. The gamma value is .060, which indicates a weak relationship level with an approximate significance level of .062. Chi square for female group, with 12.494 and 9 degrees of freedom, indicates that the probability level is .187. The gamma value for women is .052, which indicates a weak relationship. The approximate significance level is .198.

Hypothesis #4—Non-white participants will have a lesser desire for social distance than whites—will be examined by looking individually at each dependent variable's relationship with the independent variable:

Respondent Would Spend Time Socializing with a Person with a Mental Health Problem and Closeness to Person with Mental Health Problem and Race of Respondent (Table 5.0)

Race of Respondent	Respondent Would Spend Time Socializing with a Person with Mental Health Problem	Closeness to Person with Mental Health Problem				Total
		Extremely close	Very close	Not very close	Not at all close	
WHITE	Definitely willing	90 34.7%	76 24.3%	29 19.1%	13 32.5%	208 27.2%
	Probably willing	119 45.9%	162 51.8%	79 52.0%	16 40.0%	376 49.2%
	Probably unwilling	42 16.2%	59 18.8%	37 24.3%	10 25.0%	148 19.4%
	Definitely unwilling	8 3.1%	16 5.1%	7 4.6%	1 2.5%	32 4.2%
BLACK	Definitely willing	16 39.0%	20 42.6%	8 22.2%	1 8.3%	45 33.1%
	Probably willing	15 36.6%	21 44.7%	21 58.3%	8 66.7%	65 47.8%
	Probably unwilling	7 17.1%	6 12.8%	4 11.1%	3 25.0%	20 14.7%
	Definitely unwilling	3 7.3%	0 .0%	3 8.3%	0 .0%	6 4.4%
OTHER	Definitely willing	8 42.1%	5 26.3%	2 15.4%	1 14.3%	16 27.6%
	Probably willing	7 36.8%	10 52.6%	8 61.5%	3 42.9%	28 48.3%
	Probably unwilling	3 15.8%	4 21.1%	3 23.1%	3 42.9%	13 22.4%
	Definitely unwilling	1 5.3%	0 .0%	0 .0%	0 .0%	1 1.7%

For Whites ($\chi^2 = 18.082$, $df = 9$, $p < 0.05$) (Gamma = .156 $p < .001$)

For Blacks ($\chi^2 = 14.22$, $df = 9$, $p > 0.05$) (Gamma = .165 $p < .134$)

The results from figure 5.0 demonstrate that statistical significance was not reached for Black and other groups when looking at how close a respondent is to someone with a mental illness and how likely he/she is to want to socialize with someone who has a mental illness. Chi square for Black racial category, with 14.220 and 9 degrees of freedom, indicates that the probability level is .115. The gamma value is

.165, which indicates a weak relationship level with an approximate significance level of .134. Chi square for the other racial category, with 7.467 and 9 degrees of freedom, indicates that the probability level is .589. The gamma value for the middle age group is .268, which indicates a weak relationship. The approximate significance level is .118.

The chi square for the White racial category, with 18.082 and 9 degrees for freedom, indicates that the probability level is .034. The probability level is less than .05, which makes it statistically significant. The gamma level for the older age group is .156, which indicates a weak relationship, but the approximate significance level is .001.

Respondent Would Work Closely with a Person with a Mental Health Problem on a Job and Closeness to Person with Mental Health Problem and Race of Respondent (Table 5.1)

RACE OF RESPONDENT	Respondent Would Work Closely with a Person with Mental Health Problem on a Job	Closeness to Person with Mental Health Problem				Total
		Extremely close	Very close	Not very close	Not at all close	
WHITE	Definitely willing	62 24.1%	64 20.6%	37 24.0%	6 14.6%	169 22.1%
	Probably willing	116 45.1%	132 42.4%	56 36.4%	23 56.1%	327 42.9%
	Probably unwilling	57 22.2%	87 28.0%	44 28.6%	10 24.4%	198 26.0%
	Definitely unwilling	22 8.6%	28 9.0%	17 11.0%	2 4.9%	69 9.0%
BLACK	Definitely willing	15 36.6%	14 29.8%	6 17.1%	1 9.1%	36 26.9%
	Probably willing	15 36.6%	21 44.7%	15 42.9%	6 54.5%	57 42.5%
	Probably unwilling	7 17.1%	8 17.0%	10 28.6%	4 36.4%	29 21.6%
	Definitely unwilling	4 9.8%	4 8.5%	4 11.4%	0 .0%	12 9.0%
OTHER	Definitely willing	4 22.2%	3 15.8%	0 .0%	0 .0%	7 12.1%
	Probably willing	9 50.0%	9 47.4%	7 50.0%	3 42.9%	28 48.3%
	Probably unwilling	3 16.7%	5 26.3%	2 14.3%	2 28.6%	12 20.7%
	Definitely unwilling	2 11.1%	2 10.5%	5 35.7%	2 28.6%	11 19.0%

For White ($\chi^2 = 9.483$, $df = 9$, $p > 0.05$) (Gamma = .060 p .187)

For Blacks ($\chi^2 = 8.883$, $df = 9$, $p > 0.05$) (Gamma = .203 p .045)

For Others ($\chi^2 = 8.985$, $df = 9$, $p > 0.05$) (Gamma = .364 p .013)

Results from table 5.1 demonstrate that there is no statistical significance with any of the racial categories when looking at how close a respondent is to someone with a mental health problem and how likely he/she is to want to work closely with someone who has a mental health. Chi square for the White racial category, with 9.483 and 9 degrees of freedom, indicates that the probability level is .394. The gamma value is .060, which indicates a weak relationship level with an approximate significance level of .187. Chi square for the Black racial category, with 8.883 and 9 degrees of freedom, indicates that the probability level is .448. The gamma value is .203, which indicates a weak relationship. The approximate significance level is .045; this significance could be due to the large sample group. The chi square for the other racial category, with 8.895 and 9 degrees for freedom, indicates that the probability level is .439. The gamma level for this group is .364, which indicates a weak relationship, but the approximate significance level is .013.

Respondent Would Have a Person with a Mental Health Problem as a Neighbor and Closeness to Person with Mental Health Problem and Race of Respondent (Table 5.2)

RACE OF RESPONDENT	Respondent Would Have Person with Mental Health Problem as a Neighbor	Closeness to Person with Mental Health Problem				Total
		Extremely close	Very close	Not very close	Not at all close	
WHITE	Definitely willing	109	105	48	18	280
		42.2%	33.7%	31.6%	45.0%	36.7%
	Probably willing	120	158	76	16	370
		46.5%	50.6%	50.0%	40.0%	48.6%
	Probably unwilling	26	41	21	3	91
	10.1%	13.1%	13.8%	7.5%	11.9%	
	Definitely unwilling	3	8	7	3	21
		1.2%	2.6%	4.6%	7.5%	2.8%
BLACK	Definitely willing	18	21	13	3	55
		43.9%	46.7%	36.1%	25.0%	41.0%
	Probably willing	17	18	18	7	60
		41.5%	40.0%	50.0%	58.3%	44.8%
	Probably unwilling	3	4	4	2	13
	7.3%	8.9%	11.1%	16.7%	9.7%	
	Definitely unwilling	3	2	1	0	6
		7.3%	4.4%	2.8%	.0%	4.5%
OTHER	Definitely willing	7	6	1	2	16
		36.8%	31.6%	7.1%	28.6%	27.1%
	Probably willing	9	10	10	4	33
		47.4%	52.6%	71.4%	57.1%	55.9%
	Probably unwilling	1	3	3	1	8
	5.3%	15.8%	21.4%	14.3%	13.6%	
	Definitely unwilling	2	0	0	0	2
		10.5%	.0%	.0%	.0%	3.4%

For Whites ($\chi^2 = 15.758$, $df = 9$, $p > 0.05$) (Gamma = .113 p .025)

For Blacks ($\chi^2 = 4.889$, $df = 9$, $p > 0.05$) (Gamma = .101 p .367)

For Others ($\chi^2 = 9.643$, $df = 9$, $p > 0.05$) (Gamma = .172 p .327)

Results from table 5.2 demonstrate that there is no statistical significance with any of the racial categories when looking at how close a respondent is to someone with a mental health problem and how likely he/she is to want to have someone who has a mental health problem as a neighbor. Chi square for the White racial category, with 15.758 and 9 degrees of freedom, indicates that the probability level is .072. The

gamma value is .113, which indicates a weak relationship level with an approximate significance level of .025. Chi square for the Black racial category, with 4.889 and 9 degrees of freedom, indicates that the probability level is .844. The gamma value is .101, which indicates a weak relationship. The approximate significance level is .367. The chi square for the other racial category, with 10.986 and 9 degrees for freedom, indicates that the probability level is .282. The gamma level for this group is .172, which indicates weak relationship and the approximate significance level is .327.

Respondent Would Have a Person with a Mental Health Problem Care for Their Children and Closeness to Person with Mental Health Problem and Race of Respondent (Table 5.3)

Race of Respondent	Respondent Would Have a Person with Mental Health Problem Care for Your Children	Closeness to Person with Mental Health Problem				Total
		Extremely close	Very close	Not very close	Not at all close	
WHITE	Definitely willing	24 9.3%	16 5.2%	9 6.0%	3 7.3%	52 6.9%
	Probably willing	45 17.4%	46 15.1%	23 15.3%	5 12.2%	119 15.8%
	Probably unwilling	78 30.1%	99 32.5%	49 32.7%	14 34.1%	240 31.8%
	Definitely unwilling	112 43.2%	144 47.2%	69 46.0%	19 46.3%	344 45.6%
BLACK	Definitely willing	4 9.8%	0 .0%	0 .0%	0 .0%	4 2.9%
	Probably willing	7 17.1%	9 19.1%	6 16.7%	0 .0%	22 16.2%
	Probably unwilling	9 22.0%	13 27.7%	11 30.6%	3 25.0%	36 26.5%
	Definitely unwilling	21 51.2%	25 53.2%	19 52.8%	9 75.0%	74 54.4%
OTHER	Definitely willing	1 5.3%	0 .0%	0 .0%	0 .0%	1 1.7%
	Probably willing	2 10.5%	4 21.1%	2 14.3%	0 .0%	8 13.8%
	Probably unwilling	7 36.8%	9 47.4%	2 14.3%	0 .0%	18 31.0%
	Definitely unwilling	9 47.4%	6 31.6%	10 71.4%	6 100.0%	31 53.4%

For Whites ($\chi^2 = 5.248$, $df = 9$, $p > 0.05$) (Gamma = .059 p .222)

For Blacks ($\chi^2 = 13.12$ $df = 9$, $p > 0.05$) (Gamma = .170 p .135)

For Others ($\chi^2 = 13.83$, $df = 9$, $p > 0.05$) (Gamma = .356 p .032)

Results from table 5.3 demonstrate that there is no statistical significance with any of the racial categories when looking at how close a respondent is to someone with a mental health problem and how likely he/she is to want to have someone who has a mental health problem watch his/her child. Chi square for the White racial category, with 5.248 and 9 degrees of freedom, indicates that the probability level is .812. The gamma value is .059, which indicates a weak relationship level with an approximate significance level of .222. Chi square for the Black racial category, with 13.118 and 9 degrees of freedom, indicates that the probability level is .158. The gamma value is .170, which indicates a weak relationship. The approximate significance level is .135. The chi square for the other racial category, with 13.834 and 9 degrees for freedom, indicates that the probability level is .128. The gamma level for this group is .161, which indicates weak relationship, but the approximate significance level is .032.

**Respondent Would have a Person with a Mental Health Problem Marry
Someone Related to Them and Closeness to Person with Mental Health Problem and
Race of Respondent (Table 5.4)**

Race of Respondent	Respondent Would have a Person with Mental Health Problem Marry Someone Related to Them	Closeness to Person with Mental Health Problem				Total
		Extremely close	Very close	Not very close	Not at all close	
WHITE	Definitely willing	43 17.0%	25 8.3%	13 8.7%	6 14.6%	87 11.7%
	Probably willing	81 32.0%	104 34.4%	53 35.3%	10 24.4%	248 33.2%
	Probably unwilling	71 28.1%	99 32.8%	48 32.0%	15 36.6%	233 31.2%
	Definitely unwilling	58 22.9%	74 24.5%	36 24.0%	10 24.4%	178 23.9%
BLACK	Definitely willing	9 22.0%	3 6.7%	5 14.3%	0 .0%	17 12.8%
	Probably willing	15 36.6%	17 37.8%	12 34.3%	5 41.7%	49 36.8%
	Probably unwilling	7 17.1%	15 33.3%	11 31.4%	5 41.7%	38 28.6%
	Definitely unwilling	10 24.4%	10 22.2%	7 20.0%	2 16.7%	29 21.8%
OTHER	Definitely willing	3 16.7%	1 5.9%	0 .0%	1 16.7%	5 9.3%
	Probably willing	8 44.4%	4 23.5%	4 30.8%	2 33.3%	18 33.3%
	Probably unwilling	4 22.2%	8 47.1%	3 23.1%	1 16.7%	16 29.6%
	Definitely unwilling	3 16.7%	4 23.5%	6 46.2%	2 33.3%	15 27.8%

For Whites ($\chi^2 = 13.611$, $df = 9$, $p > 0.05$) (Gamma = .073 p .115)

For Blacks ($\chi^2 = 9.160$ $df = 9$, $p > 0.05$) (Gamma = .094 p .373)

For Others ($\chi^2 = 9.180$, $df = 9$, $p > 0.05$) (Gamma = .278 p .098)

Results from table 5.4 demonstrate that there is no statistical significance with any of the racial categories when looking at how close a respondent is to someone with

a mental health problem and how likely he/she is to want to have someone who has a mental health problem to marry someone related to him/her. Chi square for the White racial category, with 13.611 and 9 degrees of freedom, indicates that the probability level is .134. The gamma value is .073, which indicates a weak relationship level with an approximate significance level of .115. Chi square for the Black racial category, with 9.160 and 9 degrees of freedom, indicates that the probability level is .423. The gamma value is .094, which indicates a weak relationship. The approximate significance level is .373. The chi square for the other racial category, with 9.180 and 9 degrees for freedom, indicates that the probability level is .421. The gamma level for this group is .278, which indicates weak relationship, but the approximate significance level is .098.

Discussion

Overall, the hypotheses tested in this study were not confirmed. The first hypothesis some support was found, which looked at the general relationship between how close a respondent was with someone who had a mental disorder and each of the five dependent variables. With a probability level of .013, significance was reached in relation to how close a respondent is to someone with mental illness and how likely he/she would be to socialize with someone who has a mental illness. With a probability level of .025, significance was also reached with how close a respondent was to someone with mental illness and how much he/she would like someone with a mental health problem to marry someone in his/her family.

These results suggest that while significance was not reached for all five independent variables, there is still a connection between how close someone is to a person with a mental health problem and the amount of social distance desired. These results are similar to the results found by Link and Cullen (1986). Their research has shown that contact with the mentally ill, voluntary or involuntary, can influence perceptions of the mentally ill, which can lower the desire for social distance. Future research areas could include examining whether or not involuntary or voluntary contact has different affects on lowering the desire for social distance from those with mental illness.

The second hypothesis, which incorporated the moderating variable of age, only achieved statistical significance with one variable. With a probability level of .026, significance was reached between age, how close a respondent was to someone with a mental health disorder and how likely he/she would be to socialize with someone who has a mental disorder. However, unlike the hypothesis—the younger the participant, the less social distance would be desired—the age group that achieved significance was the middle age group (ages 36-55). Significance was not reached in any of the other four variables. This data is in contradiction with many researchers conclusions that younger groups are more tolerant than previous generations (Firebaugh and Davis 1988; Bobo et. al 1997; Martin et. al 2000). In relation to mental health, research has shown support for the idea that acceptance of those with mental health is inversely related to age (Whatley 1958; Crocetti and Lemkau 1963; Phillips 1963) The reason for a lack of significance could be due to the large grouping of the age variables. If looked at in smaller age groupings, it would be easier to pinpoint exactly which ages have a relationship between closeness to mental illness and desire for social distance.

Hypothesis #3—that women would have a lesser desire for social distance than men—was not supported by the data in this study. This reason for this could be that there is little difference between men and women in their respective desires for social distance. Another reason for this could be that, as suggested in prior research (Hinshaw, 2007), people are becoming trained to answer questions in ways that they believe are socially acceptable. This could also be the reason that no statistical significance was reached for the fourth hypothesis—that non-white racial groups would

have a lesser desire for social distance. In this hypothesis, significance was not reached in any of the variables, for any racial group. These results go against Martin et. al (2000) suggestion that those who have personally experienced prejudice (i.e., African Americans, and women) should also be less likely to have negative attitudes towards outgroups members. Aside from people being trained into what answers are socially acceptable, it could still be the case that mental illness, no matter how much personal contact or knowledge one has, is still the most stigmatizing identity one can hold.

Overall, this study does help illustrate an important aspect of mental illness and stigmatization—over time, the desire for social distance from those with mental illness has not decreased. This study shows that there is little relationship between how close someone is to a person with a mental health problem and the desire for social distance.

Better research design can also improve future scholarly inquiries into the topic. Hinshaw (2007) makes several different suggestions to improve future research. In order to avoid participants displaying social desirability with their attitudes towards mental illness and stigmatization, a different format should be used. The format he advocated is to ask participants what “most people”, “own response,” and “ideal person” would answer in response to each question asked. This should provide a less biased view on the respondent’s views. Also, research should look at behavioral indicators as well as explicit attitudes about mental illness and stigmatization. Another thing to consider when getting evidence is to ask open-ended response questions. Brockman, D’Arcy, and Edmonds (1979) found that questionnaires with a fixed format

showed weaker results for stigmatization than those studies that had open ended responses. As opposed to multiple choice questions, open ended questions do not lend themselves to suggested answers. While this method is more time consuming, it is underutilized.

Other ways research in this area could be improved include comparing mental illness with other types of disabilities. This would do much to help us understand if mental illness is still the least preferred type of disability, as prior research has shown (Hinshaw, 2007). Despite being difficult to design, another beneficial research method would be to have behavioral, interactional research to witness first-hand if participants exhibit avoidance behaviors towards those with mental illness. Future research can also look at the different types of stigmatization that occur with different types of mental illness. With a popular increase in knowledge about the different types of mental disorders, it remains important to ask if society reacts and stigmatizes differently based on the various types of mental disorder.

Overall, this study illustrates that a desire for social distance from those who have a mental illness is still present in the general population and that there are still many ways to improve upon research in this area. With more knowledge on what causes society to stigmatize against those with mental illness, we can hopefully work at reducing the desire for social distance from those with mental health issues

References

- Ajzen, I., and M. Fishnein. 1980. *Understanding Attitudes and Predicting Social Behavior*. Englewood Cliffs, NJ: Prentice-Hall.
- Alexander, Laurel A. and Bruce Link. 2003. "The Impact of Contact on Stigmatizing Attitudes Toward People with Mental Illness." *Journal of Mental Health* 12(3):271-89.
- Angermeyer, Mathias. C., Herbert Matschinger, and Patrick W Corrigan. 2004. Familiarity with Mental Illness and Social Distance from People with Schizophrenia and Major Depression: Testing a Model using Data from a Representative Population Survey." *Schizophrenia Research* 69 (2): 175-82.
- Bobo, Larry., James R. Kluegel, and Ryan A. Smith. 1997. "Laissez-Faire Racism: The Crystallization of a Kinder, Gentler, Antiblack Ideology." Pp 15-44 in *Racial Attitudes in the 1990's: Continuity and Change*, Edited by Steven A. Tuch and Jack K. Martin. Westport CT:Praeger.
- Bogardus, E. S. 1933. "A Social Distance Scale". *Sociology and Social Research* 17: 265-71.
- Brockman, J., C. D'Arcy, and L. Edmonds. 1979. "Facts or Artifacts? Changing Public Attitudes Toward the Mentally Ill." *Social Science Medicine* 13A:673-82.

- Corrigan, P.W., Annette Backs Edwards, Amy Green, Sarah Lickey Diwan, and David L. Penn. 2001. "Prejudice, Social Distance, and Familiarity with Mental Illness." *Schizophrenia Bulletin* 27(2):219-225.
- Corrigan, P.W., and A.C. Watson. 2002. "The Paradox of Self-Stigma and Mental Illness." *Clinical Psychology: Science and Practice* 9:35-53.
- Crocetti, G.W. and P.V. Lemkau. 1963. "Public Opinion of Psychiatric Home Care in an Urban Area." *American Journal of Public Health* 53:409-14.
- Davis, James A. and Tom Smith. 1996. *General Social Surveys: 1992-1996*. Chicago, IL. National Opinion Research Center.
- Davis, James A. and Tom W. Smith. 2006. *General Social Surveys: 2006*. Chicago, IL. National Opinion Research Center.
- Firebaugh, Glenn and K.E. Davis. 1988. "Trends in Anti-Black Prejudice 1972-1984 Region and Cohort Effects." *American Journal of Sociology* 94:251-72.
- Goffman, Erving. 1963. *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs, NJ: Prentice Hall.
- Hinshaw, Stephen P. 2007. *The Mark of Shame: Stigma of Mental Illness and an Agenda for Change*. Oxford: Oxford University Press.
- Lamy, R.E. 1966. "Social Consequences of Mental Illness." *Journal of Consulting Psychology* 30: 450-55.

- Lauber, Christoph., Carlos Nordt, Luis Falcató, and Wulf Rossler. 2004. "Factors Influencing Social Distance towards People with Mental Illness." *Community Mental Health Journal* 40(3) 265-72.
- Link, B. G., and F. T. Cullen. 1983. "Reconsidering the Social Rejection of Ex-Mental Patients: *Levels of Attitudinal Response.*" *American Journal of Community Psychology* 11:261-73.
- Link, B.G., and F.T. Cullen. 1986. "Contact with People with Mental Illnesses and Perceptions of How Dangerous They Are. *Journal of Health and Social Behavior* 27: 389-403.
- Link, B.G., Stueve J. Monahan, and F.T. Cullen. 1999a. "Real in their Consequences: A Social Approach to Understanding the Associations between Psychiatric Symptoms and Violence." *American Sociological Review* 64:316-22.
- Link, B.G., Jo C. Phelan, Michaline Bresnahan, Ann Stueve, and Bernice A. Pescosolido. 1999b. "Public Conceptions of Mental Illness: Labels, Causes, Dangerousness, and Social Distance." *American Journal of Public Health* 89:1328-1333.
- Link, B.G., Lawrence H. Yang, J.C. Phelan, and Pamela Y. Collins. 2003. "Measuring Mental Illness Stigma." *Schizophrenia Bulletin* 30(3):511-41.
- 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(2): 208-223.

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

Page, S. 1995. “Effects of the Mental Illness Label in 1993: Acceptance and Rejection in the Community.” *Journal of Health and Social Policy* 7:61-68.

Penn, David. L., Mary Ann Kubiak, Robert Lundin, Amy Green, and Patrick W. Corrigan. 2001. “Familiarity with and Social Distance from People who have Serious Mental Illness.” *Psychiatric Services* 52(7):953-58.

Phillips, D.L. 1963. “Rejection: A Possible Consequence for Seeking Help for Mental Disorders.” *American Sociological Review* 28:963-72.

Phillips, D.L. 1966. “Public Identification and Acceptance of the Mentally Ill.” *American Sociological Review* 29:679-87.

Spiro, Herzl. R., Iradj Siassi, and Guido Crocetti. 1974. “The Issue of Contact with the Mentally Ill.” *American Journal of Public Health* 64(9):876-879.

Struch, N., and S. H. Schwartz. 1989. “Intergroup Aggression: Its Predictors and Distinctions from Ingroup Bias.” *Journal of Personality and Social Psychology* 56:364-73.

Tringo, J.L. 1970. "The Hierarchy of Preference Toward Disability Groups." *Journal of Special Education* 4:295-306.

van't Veer, Job. T.B., Herro F. Kraan, Stans D.C. Dorsseart, and Jacqueline M. Modde.
2006. "Determinants that Shape Public Attitudes Towards the Mentally Ill."
Social Psychiatry 41:310-17.

Whately, G.C. 1958. "Social Attitudes Toward Discharged Mental Patients."
Social Problems 6:313-20.