Influence of Contact and Subjective Social Status on Stigma and Benevolence Toward Individuals with Bipolar Disorder

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Abstract

Stigma negatively impacts perceptions of individuals who have mental illnesses, and in turn, contributes to self-stigma, unwillingness to seek treatment, and unwillingness to have a relationship with a person who has a mental illness (Byrne, 2000). This study was driven by Gordan Allport's contact hypothesis, which states that one's contact with a stigmatized group will decrease stigma associated with the group. The current study evaluates how both stigma and benevolence toward people with bipolar disorder are impacted by knowing someone with bipolar disorder and the rater's subjective social status. There was not a significant difference in stigma scores for individuals who have contact with someone who has bipolar disorder compared to someone who does not have contact with someone with bipolar disorder, but individuals who know someone who has bipolar disorder scored higher on benevolence than those who do not know someone with bipolar disorder. Subjective social status was significant as a predictor of stigma, while subjective social status was not a significant predictor of benevolence toward people with bipolar disorder. This study provides partial support for contact theory, and enhances our understanding of how positive and negative attitudes about people with bipolar disorder are affected by contact and social status.

Keywords: contact theory, benevolence, subjective social status, stigma, bipolar disorder

Influence of Contact and Subjective Social Status on Stigma and Benevolence Toward Individuals with Bipolar Disorder

Stigma and its Effect on Societal Perceptions

Stigma is a negative perception of a group, driven by negative stereotypes of individuals. Stigma about mental illness is pervasive and leads to a distorted perception of how people with mental disorders think and behave (Corrigan & Watson, 2002). Stigma of mental illness impacts self-stigma, willingness to seek treatment, perceived dangerousness, and willingness to have a relationship with a person with mental illness (Byrne, 2000; Kosyluk et al., 2016; Phelen & Basow, 2007).

According to the National Institute of Mental Health, the prevalence of mental illness in America is one in every five individuals, which was estimated to be about 51.5 million people in 2019 (The National Institute of Mental Health, 2021). With such a vast prevalence of individuals affected by mental illness, why is there still stigma burdening society's attitudes and perceptions? Stigma must be eradicated as it continues to exacerbate a national mental health crisis, however, what will it take to dismantle the barriers of stigma and gain an acceptance toward mental health being equally as important as physical health? In time, a reduction of stigmatic perceptions could have a positive impact on individuals with mental illness. The eradication of stigma will benefit society as a whole, increasing the quality of life for all individuals who have a mental illness.

Stigma and Bipolar Disorder

Bipolar disorder is a mental illness characterized by cycles of mania and depression. Depending on the severity of the illness, it can be diagnosed as either type I, type II, or cyclothymic disorder. Bipolar disorder can cause an interruption in one's lifestyle when symptoms of the illness become severe, causing financial burden when the individual undergoes

treatment especially when hospitalization, outpatient treatments, and comorbid conditions are applicable (Bessonova et al., 2020). However, effective treatments are available, and an individual with bipolar disorder can expect a normal level of functioning when the proper treatment is utilized. Upon return to regularly scheduled activities after treatment/hospitalization has been completed, fear of stigma and judgment could result in the individual not returning to previous careers and/or activities once enjoyed. Stigma causes a distressing burden on those with mental illness, affecting their willingness to seek treatment, causing a decrease in their self esteem and increase in the severity of their symptoms (Cuttler & Ryckman, 2019).

Cassidy and Erdal (2020) showed that interventions focused on exposure and education about the effective treatments for individuals with bipolar disorder reduced stigmatic attitudes in participants. They discovered that stigma was reduced when information was given to the participants regarding causal factors for bipolar disorder, namely biological factors which are out of one's control (Cassidy & Erdal, 2020). In addition to educational intervention, changing language is also associated with reductions in stigma. Ellison et al. (2015) studied the effect of renaming bipolar disorder as 'manic depression' and schizophrenia to 'integration disorder;' this study also measured public stigma. Renaming disorders elicited more fear responses and did not decrease stigmatic perceptions. More social distance was desired when utilizing renamed disorders in contrast to using the actual diagnosed label of 'bipolar disorder' and 'schizophrenia' (Ellison et al., 2015). Something unfamiliar is even more stigmatized than something familiar. Similar to renaming, noun labeling is one important new change in culture, and is the drive to think about each person with a disorder as a person first before their illness. Labeling individuals with their illness is also detrimental, for instance, calling someone bipolar rather as a 'person with bipolar disorder.' Cuttler and Ryckman (2019) studied the effects of noun labeling in their

sample of participants and found that misusing psychological diagnoses as labels is highly detrimental and results in stigmatizing attitudes and perceptions. Hence, there is some evidence that stigma is a variable that can be reduced.

Benevolence toward those with mental illness

Ahuja et al. (2017) examined benevolence and stigma toward those with mental illness. Participants experienced contact with an individual who spoke during this intervention who was diagnosed with schizophrenia (Ahuja et al., 2017). Notably, this study's findings include a significant decrease in noun labeling and increase in positive attitudes toward individuals with mental illness in the post assessment of the participants after education and contact were utilized; this assisted in curbing stigma and imposing benevolence. The CAMI (Community Attitudes Toward the Mentally Ill) scale exhibited significant improvement in social restrictiveness and benevolence, while community mental health ideology and authoritarianism were not significant in this sample (Ahuja et al., 2017). Acceptance of mental illness was apparent in this study, as benevolence was increased as a result of education about mental illness. Contact influenced these significant findings - in this study, contact existed between the speaker and the participants.

Contact Theory

Allport described the influence of contact on prejudice and discriminatory perceptions, specifically "contact hypothesis," which states that contact between two groups can induce an embrace of differences between groups under certain guidelines of "common goals," "equal status," "cooperation," and "authority sanction" (Allport, 1954; DeAngelis, 2001; Pettigrew & Tropp, 2006). Pettigrew and Tropp (2006) conducted a meta-analysis of 713 samples from 515 studies, testing Allport's contact theory. Results of their findings included that conditions of common goals, equal status, cooperation, and authority sanction are catalysts for inducing

positive results from contact. Thus, one could expect that having contact with an individual in a stigmatized category would be associated with opportunities to have common goals, equal status, and cooperation, and thus be associated with reduced stigma. Since Allport's contact theory targets the idea that if two groups have a common condition, contact between individuals will influence acceptance (DeAngelis, 2001; Phelan, Lucas, Ridgeway, & Taylor, 2014). In this present study, we test Allport's theory specifically for bipolar disorder, namely participants who have a relationship with someone who has bipolar disorder will show less stigma than those who do not know someone with bipolar disorder.

Subjective Social Status and Stigma

Phelan, Lucas, Teachman et al. (2019) proposed the idea that there is a separation in society between individuals with a mental illness and those who do not have a mental illness. With this, stigma affects a low socioeconomic status person more with a mental illness than it would to a person who is of a lower social status without a mental illness. Differences between age, gender, education, income, and socioeconomic status, all contribute to the stigma that an individual receives despite being diagnosed with a mental illness (Phelan, Lucas, Teachman et al., 2019). Social rejection and willingness of individuals to be socially distanced from those with a mental illness contributes to the result of lack of benevolence because of decreased contact with individuals of diverse groups/alternative status. People with a mental illness are treated as if they are of a lower status, while also experiencing social rejection and distance from individuals who do not have a mental illness. Higher socioeconomic status is linked to having access to a plethora of resources, such as income, a social network, and education (Phelan, Lucas, Ridgeway, & Taylor, 2014). Foster et al. (2018) explored the relationship between socioeconomic status, personal acquaintance, empathy, mental illness prejudice, and knowledge

of mental illness. Higher subjective SES was associated with higher levels of prejudice for depression and mental illness (nonspecified), though not for schizophrenia. Interestingly, the lower socioeconomic status reported correlated with more knowledge about the mental illnesses. The more the knowledge about mental illness, the higher the empathy (Foster et al., 2018).

Stigma and Subjective Social Status in Elite College Culture

Billings (2020) studied personal and perceived stigma in college students from an elite (Ivy League) and a non-elite (non-Ivy League) private college. Significant findings include that Ivy League students showed greater personal stigma about mental illness than non-Ivy League university students. In the elite institution, experience with mental illness for self or a family member was associated with less stigma, which is consistent with contact theory. In the elite institution, subjective social status was a predictor of both perceived and personal stigma, with lower social status associated with more stigma. At the non-elite institution, higher social status was associated with more stigma. In both institutions, lower status students are more likely to have psychological disorders and not receive any treatment due to the stigma surrounding the college community (Billings, 2020; Eisenberg et al., 2007; Hunt & Eisenberg, 2010; Rosenthal & Wilson, 2008). Billings (2020) found that students who were of low socioeconomic status were more likely to exhibit empathetic behavior and understand the struggles of their family and friend's who may be experiencing mental illnesses (Billings, 2020). Context seems to matter, and subjective social status is associated with stigma, but might depend on whether lower status individuals feel particularly excluded in an elite setting.

The present study will contribute to the literature by learning more about how contact, and social status are associated with stigma and benevolence. The current study will examine

subjective social status and contact as a way of predicting stigma and benevolence toward individuals who have bipolar disorder in a sample of college students.

Hypotheses

Based on the review, the hypotheses for this study will examine how contact and social status impact both negative (stigma) and positive (benevolence) attitudes about individuals with bipolar disorder. It is hypothesized that:

Hypothesis 1: Contact with a person with bipolar disorder will be associated with less stigma toward people with bipolar disorder.

Hypothesis 2: Contact with a person who has bipolar disorder will be associated with more benevolence toward people with bipolar disorder.

Hypothesis 3: Students with a higher subjective social status will have more stigma toward people with bipolar disorder.

Hypothesis 4: Students with a higher subjective social status will have less benevolence toward people with bipolar disorder.

Method

To understand more about how contact and subjective social status impact stigma and benevolence towards people with bipolar disorder, we recruited a convenience sample of adults ages 18 and older to complete an anonymous online survey. Participants were all undergraduate students at Stockton University and were recruited through a student research participation database (SONA). Access to SONA is provided through academic courses, including Introduction to Psychology, Abnormal Psychology, Perception, and other psychology courses. The questionnaire and psychological scales were distributed electronically to students. The final sample consisted of 71 participants. Students received 1 course credit toward their psychology

courses and may have received credit or extra credit in their course for participation as per course instructor. The survey took approximately 20 minutes to complete. Qualtrics software was utilized to create the survey. SPSS Version 14 was used for statistical analysis.

Participants

The number of participants recruited for this experiment was a total of n=71 undergraduate Stockton students. All participants were at least 18 years old. Participants were not restricted to any psychology course offered at Stockton University.

Measures

Demographic and clinical characteristics

Demographic information included age, gender, race/ethnicity, major/ minor/ concentration or program, expected year of graduation, and have you ever been diagnosed with bipolar disorder. Individuals who had been diagnosed with bipolar disorder themselves were excluded from analyses.

Stigma

Stigma was measured by the Stigma-EMIC community version scale. This scale consists of 15 questions, where "bipolar disorder" took the place of "condition" in the original scale (see Appendix A). This scale has been proven valid and reliable as a measurement of public/community stigma, specifically in regard to diseases and conditions, and have been used in countries where tropical diseases are stigmatized (Frota da Rocha Morgado et al., 2020). Additionally, it has been used during interviews with psychiatric patients (Frota da Rocha Morgado et al., 2020).

Benevolence

Benevolence was measured using a subscale of the Community Attitudes towards the Mentally Ill scale. This scale has 40 items, with subscales that assess authoritarianism, benevolence, social restrictiveness, and community mental health ideology. This scale has been used extensively in research which contributes to the efficacy of the scale (Ahuja et al., 2017). This scale was developed in the 1970s, and continues to be used to measure community attitudes toward those with mental illnesses worldwide (Taylor & Dear, 1981). Both pro and anti benevolence questions are embedded within specific questions in the benevolence subscale, and reverse scoring was utilized for anti benevolence analysis. In the present study, the research team collected data from all subscales of authoritarianism, benevolence, community mental health ideology, and social restrictiveness, but benevolence was the only subscale that was used and reverse scored in statistical analysis (see Appendix B).

Contact

Contact was measured qualitatively by asking a yes or no question if the participant knows someone who has bipolar disorder. Participants were also asked about their relationship with the person who has bipolar disorder (i.e. parent, sibling, other relative, friend, spouse, coworker, boss, neighbor, etc), and the frequency of their interaction/contact.

Social Status

The MacArthur Scale of Subjective Social Status- Adult Version measures subjective social status and consisted of two questions containing a ladder that has 10 rungs; the first question measures socioeconomic status in relation to one's standing in the United States, and the second question measures one's socioeconomic status compared to their community. An advantage of this measure is its ability to measure socioeconomic status without providing quantitative data, such as income. In this study, a ladder that has rungs from 1-10 were visible for

participants to visualize where they can see themselves in contrast to either the country or community. Regression analysis was conducted for the first item of the MacArthur Scale of Subjective Social Status- Adult version scale (comparison to the United States) was used in the analyses for this paper (see Appendix C). Both questions were tested separately using regression analysis, but when combined, yielded null results.

Procedure

Participants participated through Stockton University's SONA psychology lab by signing up for an available time slot to complete the study, and had access to the online survey Qualtrics link. The first page of the survey on Qualtrics was a consent form and participants who consented to the study for participation gained access to the study. Participants were asked various demographic questions, as well as if they have any contact with an individual who has bipolar disorder, and if they do or do not have bipolar disorder themselves. Anyone who reported that they had been diagnosed with bipolar disorder were excluded from the study. Data was collected for two weeks from March 19th to April 2nd, 2021.

Statistical Analysis

Two independent samples t tests were used to test differences in stigma and benevolence for those with and without contact with a person who has bipolar disorder, specifically testing contact theory in both hypothesis 1 and hypothesis 2. Two regression analyses were conducted, with the MacArthur Scale of Subjective Social Status scale as the independent variable, and benevolence and also stigma as the dependent variables.

Results

In the sample (n=71), n=58 were female (81.6%), n=6 were male (8.4%), n=2 were non-binary (2.8%), and n=1 was not applicable (1.4%). There were n=4 participants who did not

consent to completing the study (5.6%). The mean age was *M*= 20.34 (*SD*=3.18) and 69% of the sample was made up of participants aged between 18-20 years old. Most of the participants were psychology majors (n=35, 49.1%), with a range of majors including biology, criminal justice, health science, social work, and other fields participated in this study.

Ten participants (14.9%) reported that they had bipolar disorder themselves and were excluded from further analyses. Out of n=57 who answered the question about contact with someone who has bipolar disorder, n=33 participants (57.9%) did report knowing someone with bipolar disorder.

The mean score on the 10 point scale of subjective social status was *M*=5.39, *SD*=1.38. This was a sample that overall identified as middle class.

Hypothesis 1 stated that participants who know someone with bipolar disorder would have less stigma than those who did not know someone with bipolar disorder. This hypothesis was not supported; there was not a significant difference in stigma scores for individuals who have contact with someone who has bipolar disorder (*M*=12.93, *SD*=6.21) compared to someone who does not have contact with someone with bipolar disorder (*M*=8.63, *SD*=8.38; t(23) = 11.473, p>0.05, 95CI [-10.632, 1.74)].

Hypothesis 2 stated that contact would be associated with more benevolence. This was supported; individuals who know someone who has bipolar disorder (*M*=43.38, *SD*=4.93) scored higher on benevolence than those who do not know someone with bipolar disorder (*M*=40.04, *SD*=5.55; t(53) = -2.362, p<.05, 95CI [-0.505, -6.19]).

Hypothesis 3 stated that individuals with higher subjective social status would have higher levels of stigma. This was supported; subjective social status compared to others in the United States was significant as a predictor of stigma, β=2.194, t(23)=0.483, p<.05. Subjective

social status explained a significant portion of the variance in stigma scores, ($R^2 = .233,\ F(1, 23) = 7.002,\ p = 0.014$).

Hypothesis 4 stated that higher social status would be associated with lower levels of benevolence. This was not supported; subjective social status compared to those in the United States was not a significant predictor of benevolence toward people with bipolar disorder, $\beta = 0.615$,=0.615, t(53)= 1.347, p>.05. Subjective social status did not explain a significant portion of the variance in benevolence scores, ($R^2 = .033,\ F(1, 53) = 1.1815,\ p = .184$).

Discussion

This study was designed to learn more about stigma and benevolence toward people with bipolar disorder, specifically how contact with someone with bipolar disorder and social status impact a positive outcome variable (benevolence) as well as a negative outcome variable (stigma). The relationship between social status and the outcome variables of stigma and benevolence were hypothesized to be additional significant indicative factors of public stigma, namely identifying how individuals with a higher subjective social status view individuals with mental illness/bipolar disorder.

Hypothesis 1 was not supported; there was not a significant difference in stigma scores for individuals who have contact with someone who has bipolar disorder (*M*=12.93, *SD*=6.21) compared to someone who does not have contact with someone with bipolar disorder (*M*=8.63, *SD*=8.38; t(23) = 11.473, p=.154, 95CI [-10.632, 1.74)]. The lack of significant findings for this relationship can be attributed to participants not completing the entirety of the Stigma-EMIC Community Version Scale and not correctly completing the demographic questions regarding if they have contact with someone who has bipolar disorder. Perhaps a larger sample size would have been beneficial to compensate for a large gap in missing data.

Hypothesis 2 was supported, with our results suggesting that individuals who know someone who has bipolar disorder have more benevolent feelings about people with bipolar disorder than those who do not know someone with bipolar disorder ($t(53) = 2.362$, $p=.022$, 95CI [0.505, 6.19]). This significant finding sheds light on the empathy that an individual gains when contact is applied to the relationship between an individual who has a bipolar disorder and another individual who does not have a bipolar disorder. Similarly, researchers Foster et al. (2018) unpacked the idea that the more knowledge an individual has about mental illness, the more empathy that person will have for those with mental illness. If contact results in knowledge, then it might also result in more benevolence.

Hypothesis 3 was supported, with participants who reported a higher subjective social status reporting more community stigma toward individuals with bipolar disorder, which is consistent with prior work on subjective social status and stigma. Subjective social status was significant as a predictor of stigma, ($\beta=2.194$, $t(23)=0.483$, $p<.05$). Subjective social status explained a significant portion of the variance in stigma scores ($R^2 = .233, F(1,23)=7.002, p=0.014$). Billings (2020) found that subjective social status was associated with more stigma in the non-elite institution from which we collected data. If 1 in every 5 Americans have a mental illness, this has to be indicative of the importance for mental health awareness that must be discussed in order to benefit people's quality of life and change societal perceptions toward those with a mental illness.

Subjective social status is significantly associated with more stigma, as the higher a person's subjective social status is, the more community stigma they report. However, it is important to note that the stigma that was measured was community stigma, not personal stigma,

and therefore we can most accurately conclude that the higher a person's social status, the more aware they are of the mental health stigma existing within their communities.

Hypothesis 4 showed that subjective social status is not predictive of benevolence toward those who have bipolar disorder, $\beta=0.615$, $t(53)= 1.347$, $p>.05$. Subjective social status did not explain a significant portion of the variance in benevolence scores, $R^2=.033$, $F(1,53)=1.1815$, $p=.184$. The results of this study are important, since an individual's subjective social status is not indicative of how kind (benevolent) they are toward individuals with bipolar disorder, but shows they are aware of the stigma that exists toward people with bipolar disorder at the very least. In contrast to this study, Ahuja et al. (2017) utilized the CAMI scale and found significant increases in a participant's benevolence and social restrictiveness in their pre and post one week educational interventions and assessments of their sample. With this, education about mental illness is proven to show desirable results toward the reduction of stigmatic attitudes and perceptions of individuals with mental illnesses. It is with hope in the future that individuals continue to advocate for the reduction of mental health stigma regardless of an individual's SES. Awareness that the stigma exists is an important first step in making an impactful difference in society.

Limitations

One problem with this study was the high rates of missing data from participants, especially for the stigma items, in which just 25 participants completed the full scale. This may explain the null results. It is notable that with a larger sample of complete data for benevolence (n=55), significant results were obtained in the hypothesized direction. Future research with more participants may elicit significant differences in stigma based on contact. Perhaps an

incentive to participate in research (i.e. monetary reward) may have resulted in a more complete data set and more participants.

The sample was undergraduate college students and therefore not generalizable to the rest of the population. If this study were conducted differently or continued as a replication study in the future, the research team could include graduate students, community members, and more variety in age and socioeconomic status. The amount of education in psychology and personal experience can be indicative of a person's empathic nature, and may influence the results.

Additionally, a more nuanced assessment of stigma, especially personal stigma, should be included in future research. Perceived stigma, or community stigma, was measured in this study, however, both perceived and public stigma would create more meaningful conclusions about mental health stigma in an individual and identify targets for interventions to reduce stigma.

Another limitation of this study was the small sample size that could have been enlarged by length of data collection. Type of relationship could also influence contact's impact on stigma and benevolence, and could be further explored in future investigations. Lastly, this study's sample was made up of mostly females, middle social status, and young adults. In future investigations, if subjective social status is explored, there should be a more diverse sample. Perhaps comparing and contrasting Stockton University to Atlantic Cape Community College or other undergraduate institutions could be useful for generating meaningful results when a mix of socioeconomic backgrounds and ages are applicable, which could result in more data participation and give credibility due to the larger population.

Conclusion

This study demonstrates the importance of understanding attitudes about people with bipolar disorder in a sample of college students. By including both stigma and benevolence, we

can learn more about negative as well as positive outcomes measures, which is an important goal of the field of positive psychology. It is important to discuss and spread awareness about mental health in order to recognize how to dismantle the barriers of stigma as well as enhance empathy towards those with a mental illness. Contact with someone who has a mental illness can impose benevolence toward not only the individual who they know has a mental illness, but may also spread this empathy to other individuals in the community who have a mental illness. More recently, there has been an improvement of societal acceptance in talking about mental illness, which individuals are more willing to talk about mental illnesses (Lipson et al., 2018). In today's society, there is wider acceptance for individuals regardless of their backgrounds, which could positively influence a reduction of stigma (i.e. no tolerance allowed for prejudice toward an individual's SES when applying for a job). Perhaps with increased awareness and honest conversations about experiences with mental illnesses we will realize that most of us do know someone with mental illness and can express benevolence toward them. Further research with stigma reduction will promote benevolence and awareness of mental health to the population, aiding in the goal to ultimately eradicate the stigma of mental illness. Acceptance can be the glue that reconnects the severed barriers created by stigma between individuals with mental illness and those who do not have a mental illness.

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Appendix A

STIGMA-EMIC (community version)

We are trying to conduct research in order to identify the needs of people with bipolar disorder in the area. Please answer the following short questions about the views of the community regarding bipolar disorder.

Question	Yes	Possibly	No	Don't Know
1. Would a person with bipolar disorder try to keep others from knowing?	○	○	○	○
2. If a member of your family had bipolar disorder, would you think less of yourself, because of this person's problem?	○	○	○	○
3. In your community, does bipolar disorder cause shame or embarrassment?	○	○	○	○
4. Would others think less of a person with bipolar disorder?	○	○	○	○
5. Would knowing that someone has bipolar disorder have an adverse effect on others?	○	○	○	○
6. Would other people in your community avoid a person affected by bipolar disorder?	○	○	○	○
7. Would others refuse to visit the home of a person affected by bipolar disorder?	○	○	○	○
8. Would people in your community think less of a family of a person with bipolar disorder?	○	○	○	○
9. Would bipolar disorder cause problems for the family?	○	○	○	○
10. Would a family have concern about disclosure if one of their members had bipolar disorder?	○	○	○	○
11. Would bipolar disorder be a problem for a person to get married?	○	○	○	○

12. Would bipolar disorder cause problems in an ongoing marriage?	○	○	○	○
13. Would having bipolar disorder cause a problem for a relative of that person to get married?	○	○	○	○
14. Would having bipolar disorder cause difficulty for a person to find work?	○	○	○	○
15. Would people dislike buying food from a person affected by bipolar disorder?	○	○	○	○

Appendix B

Instructions and questions taken from the Community Attitudes Toward the Mentally Ill Scale. All questions have options of strongly agree, agree, neutral, disagree, strongly disagree for answers. **Pro benevolence questions are b., j., r., z., and hh. Anti benevolence questions are f., n., v., dd., and ll; these were reverse scored in statistical analysis. Both pro and anti benevolence subscale questions that are embedded with the CAMI scale have been bolded.** Other subscales include authoritarianism, social restrictiveness, and community mental health ideology.

Instructions: The following statements express various opinions about mental illness and the mentally ill. The mentally ill refers to people needing treatment for mental disorders but who are capable of independent living outside a hospital. Please enter the response which most accurately describes your reaction to each statement. It's your first reaction which is important. Don't be concerned if some statements seem similar to ones you have previously answered. Please be sure to answer all statements.

a. As soon as a person shows signs of mental disturbance, they should be hospitalized.
b. More tax money should be spent on the care and treatment of the mentally ill.
c. The mentally ill should be isolated from the rest of the community.
d. The best therapy for many mental patients is to be part of a normal community.
e. Mental illness is an illness like any other.
f. The mentally ill are a burden on society.
g. The mentally ill are far less of a danger than most people suppose.
h. Locating mental health facilities in a residential area downgrades the neighborhood.
i. There is something about the mentally ill that makes it easy to tell them from normal people.
j. The mentally ill have for too long been the subject of ridicule.
k. A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered.
l. As far as possible, mental health services should be provided through community- based facilities.
m. Less emphasis should be placed on protecting the public from the mentally ill.
n. Increased spending on mental health services is a waste of tax dollars.
o. No one has the right to exclude the mentally ill from their neighborhood.
p. Having mental patients living within residential neighborhoods might be good therapy, but the risks to residents are too great.
q. Mental patients need the same kind of control and discipline as ayoung child.
r. We need to adopt a far more tolerant attitude toward the mentally ill in our society.
s. I would not want to live next door to someone who has been mentally ill.
t. Residents should accept the location of mental health facilities in their neighborhood to serve the needs of the local community.
u. The mentally ill should not be treated as outcasts of society.
v. There are sufficient existing services for the mentally ill.
w. Mental patients should be encouraged to assume the responsibilities of normal life.

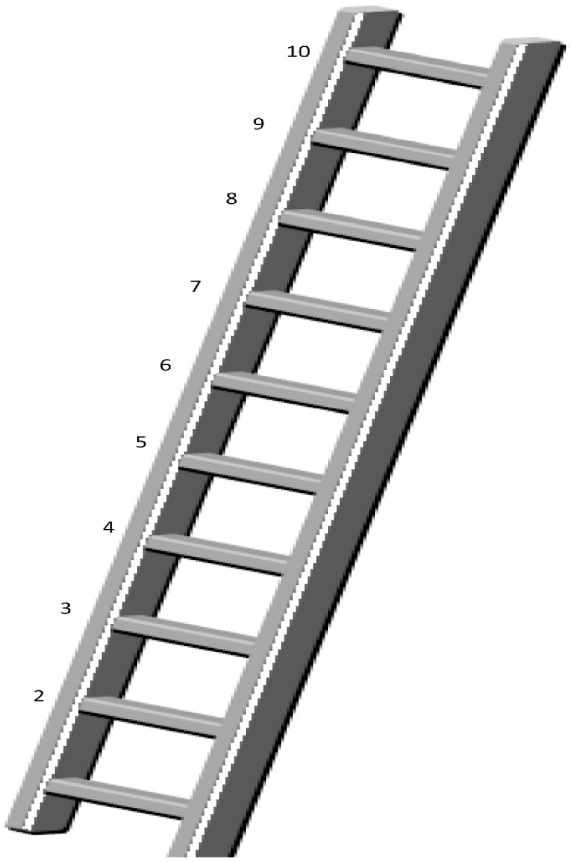
x. Local residents have good reason to resist the location of mental health services in their neighborhood.
y. The best way to handle the mentally ill is to keep them behind the locked doors.
z. Our mental hospitals seem more like prison than like places where the mentally ill can be cared for.
aa. Anyone with a history of mental problems should be excluded from taking the public office.
bb. Locating mental health services in residential neighborhoods does not endanger local residents.
cc. Mental hospitals are an outdated means of treating the mentally ill.
dd. The mentally ill do not deserve our sympathy.
ee. The mentally ill should not be denied their individual rights.
ff. Mental health facilities should be kept out of residential neighborhoods.
gg. One of the main causes of mental illness is a lack of self-discipline and will power.
hh. We have the responsibility to provide the best possible care for the mentally ill.
ii. The mentally ill should not be given any responsibility.
jj. Residents have nothing to fear from people coming into their neighborhood to obtain mental health services.
kk. Virtually anyone can become mentally ill.
ll. It is best to avoid anyone who has mental problems.
mm. Most women who were once patients in a mental hospital can be trusted as babysitters.
nn. It is frightening to think of people with mental problems living in residential neighborhoods.

Appendix C

MacArthur Scale of Subjective Social Status - Adult Version

Instructions: Think of this ladder as representing where people stand in the United States. At the top of the ladder are the people who are the best off – those who have the most money, the most education, and the most respected jobs. At the bottom are the people who are the worst off – those who have the least money, least education, the least respected jobs, or no job. The higher up you are on this ladder, the closer you are to the people at the very top; the lower you are, the closer you are to the people at the very bottom.

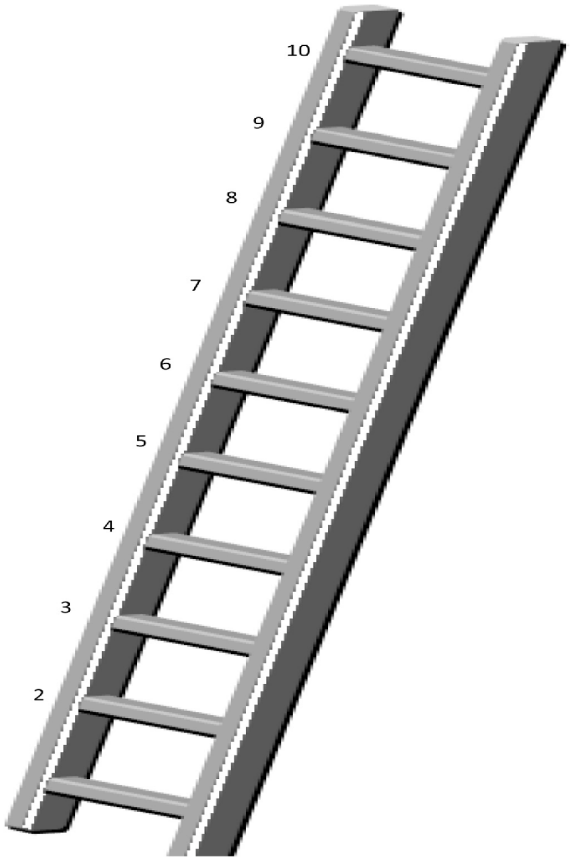
Where would you place yourself on this ladder?



Please select a number, 1-10 pertaining to the rung where you think you stand at this time in your life relative to other people in the United States.

Instructions: Think of this ladder as representing where people stand in their communities. People define community in different ways; please define it in whatever way is most meaningful to you. At the top of the ladder are people who have the highest standing in their community. At the bottom are the people who have the lowest standing in their community.

Where would you place yourself on this ladder?



Please select a number, 1-10, pertaining to the rung where you think you stand at this time in your life relative to other people in your community.