Telephone Survey of Missourians Regarding Attitudes Toward People with Mental Illness

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Division of Comprehensive Psychiatric Services (CPS)
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Table of Contents

MISSOURIANS' ATTITUDES TOWARD MENTAL ILLNESS
TELEPHONE SURVEY
EXECUTIVE SUMMARY

The results of this study are from a random telephone survey of 1,001 adult Missourians conducted in Summer 2006 for the Division of Comprehensive Psychiatric Services (CPS), Missouri Department of Mental Health. The survey was developed and analyses were conducted by researchers at the Missouri Institute of Mental Health, and administered by researchers at the Health and Behavioral Risk Research Center, both of which are part of the University of Missouri-Columbia.

Experience with Mental Illness

- Based on a random sample of adults, a majority of Missourians have had some personal experience with mental illness. A large proportion of Missourians sampled reported knowing (64%) or living near (40%) someone with a mental illness at some point in time.

- Approximately 20% of Missourians reported having suffered from a mental health problem. Almost all (88%) of those who sought treatment felt it was helpful.

- Of those who did not seek help for their illness, the most commonly stated reasons were that they felt they could handle it on their own (68%), treatment was too expensive (61%), or the problem would go away on its own (54%).

Mental Illness Stigma

- Compared to data from 1950, Missourians are far less likely to define persons with mental illness as psychotic, and less likely to feel that all mentally ill people are dangerous.

- The majority of those surveyed would be willing to associate with persons with a mental disorder. However, they would be much more willing to move next door to or make friends with a person with mental illness than to work closely with or have that person marry into their family.

- The best predictor of stigma was the perceived dangerousness of the mentally ill individual.

- Respondents who were over 65, male, from suburban areas, were more highly educated, or had a higher income were most reluctant to have a person with mental illness to work with or marry into their family.

- Of the disorders, schizophrenia was by far the most stigmatized. Respondents viewed persons with schizophrenia as very likely to be violent toward both themselves and others. Perhaps due to this perception, respondents were least willing to interact with persons with schizophrenia, especially males. Missourians felt violence towards others was least likely for those with PTSD or elderly depression.

- Those who have known someone with mental illness, or have experienced mental illness themselves, were less likely to believe that a person with mental illness would be violent towards him or herself.

Knowledge of Mental Illness

- Respondents were most likely to correctly identify major depressive disorder (MDD), depression that occurs in the elderly, and post-traumatic stress disorder (PTSD). They were least likely to be able to correctly identify bipolar disorder and schizophrenia. Females, more educated respondents, suburban respondents, and those with more personal experience with mental illness were most successful in correctly identifying the mental illnesses described.

- Perceived causes of mental illness were highly dependent upon the type of mental illness described. Major depression and post-traumatic stress were felt to be most likely caused by stress. Elderly depression was perceived to be a result of stress and the normal response to aging. A chemical imbalance was felt to be the most likely cause of schizophrenia and bipolar disorder, but was also important for MDD and elderly depression. Genetics were perceived to be important causes of all illnesses except PTSD.

Treatment of Mental Illness

- Almost all (93%) respondents felt that mental illness could improve with treatment. Respondents in urban (non-suburban) areas, males, and those with lower educational levels were more likely to believe the illness would improve on its own, and less likely to believe it would improve with treatment.

- Most respondents felt that Medicaid or Medicare should have either primary or secondary responsibility for the cost of mental health treatment.

SUMMARY OF FINDINGS

In Summer 2006, a random telephone survey of 1,001 adult Missourians was conducted for the Division of Comprehensive Psychiatric Services (CPS), Missouri Department of Mental Health (MDMH) to learn more about Missourian's attitudes toward persons with mental illness in the State. The eventual purpose of the survey was to use this knowledge to develop a statewide anti-stigma campaign. The survey was created and analyses conducted by researchers at the Missouri Institute of Mental Health (MIMH). The survey was administered by researchers at the Health and Behavioral Risk Research Center (Center). Both MIMH and the Center are part of the University of Missouri-Columbia.

After a comprehensive review of the anti-stigma literature and discussions with key staff of the funding agencies, it was determined that the survey should focus upon causes and perceptions of mental illness, comfort levels with associating with persons with mental illness, and familiarity with and treatment of mental illnesses. Researchers used the Mental Health Module of the General Social Survey. The survey concentrated on five major mental illnesses: schizophrenia, bipolar disorder, major depressive disorder (MDD), Post-Traumatic Stress Disorder (PTSD), and depression among the elderly. Each respondent was read a description of a person with one of these conditions (without naming the illness) and asked a series of questions regarding that person and their illness. Two hundred respondents were asked about schizophrenia, 200 hundred about bipolar disorder, 200 about major depressive disorder (MDD), 200 about elderly depression, and 200 about Post Traumatic Stress Syndrome (PTSD). Because of the need to adequately address their mental health needs, African-Americans were oversampled, with a sample size of 225 (See Table 1, pg 11).

Key Findings

Personal Experience with Mental Illness

- Results suggest that a majority of Missourians have had some personal experience with mental illness. A large proportion of Missourians sampled reported knowing (64%) or living near (40%) someone with a mental illness at some point in time.

- The findings for help-seeking are promising. Results suggest that a large proportion of those who have felt like they had mental illness (73.7%) sought help, and of those that sought help, a large majority believe the treatment helped (88.3%).
    - Still, as promising as those numbers are, approximately one-fourth of those who felt they had a mental health problem did not seek treatment. Main reasons given were because they felt able to handle the problem on their own and that treatment was too expensive.
        - Men were slightly more likely to say they could handle the problem on their own. Those who felt the treatment was too expensive had slightly lower income than those who did not cite expense as a reason for not seeking treatment.

The Causes of Mental Illness

- Education (whether from formal sources or personal experience) seems to be a driving force behind eliminating myths related to mental illness. Respondents with less education and less familiarity with mental illness were least knowledgeable about the causes of mental illness.

- Those in urban or rural areas, older adults, and males were more likely to feel mental illness was a result of bad character.
    - In terms of older adults and those in urban and rural areas, this finding is most likely at least partially the result of less education about the causes of mental illness in those groups. However, analyses suggest that education does not completely account for the difference.
        - Since differences in income, ethnicity, and personal experience also do not account for the differences between urban, suburban, and rural respondents, it is likely the finding reflects a true geographic dissimilarity in attitudes about mental illness.
        - Further analyses of older adults' tendency to attribute mental illness to bad character suggested that their opinions were not due to lower educational levels. Instead, their opinions may be the result of generational beliefs about mental illness.
    - Why males in the sample were more likely to attribute mental illness to bad character is unclear. Since analyses of our sample indicate no gender differences in either formal education or personal experience with mental illness, it seems likely that our finding may be at least partially attributed to socialization that encourages males to be tough, independent, and under emotional control (Addis & Mahalik, 2003). Males may see those that fail to express these qualities as weak, or in the case of this sample, having "a bad character."

Recognizing Mental Illness

- As with the causes of mental illness, those better educated, those in suburban areas, and females were better at recognizing mental disorders, and more likely to recognize them as mental illnesses, not as a result of normal life or physical illness.

- In general, respondents were more likely to believe that individuals with elderly depression were experiencing normal life, and less likely to believe that individuals with PTSD were experiencing mental illness. These results may reflect a tendency to underestimate those two conditions as mental illnesses, and in the case of elderly depression, misattribute it as the result of the normal aging process.

The Stigma of Mental Illness

- Although urban and rural respondents were less educated about the causes of mental illness, and less able to recognize mental illness, they were less likely than individuals in suburban areas to stigmatize a mentally ill individual. Stigma is also more common among the elderly and males.

- Perceived dangerousness of the mentally ill is one of the best predictors of stigma. The survey results suggest that the perception of mentally ill persons as dangerous is pervasive across all regions and demographics. Only those with personal experience with mental illness were less likely to perceive the mentally ill as dangerous.

- Of the disorders, schizophrenia was by far the most stigmatized. Respondents viewed the schizophrenic individual as very likely to be violent towards both him or her and others, and this effect was stronger if the person was male. Respondents were also least willing to interact with a schizophrenic individual in all situations.

- PTSD and elderly depression were the least stigmatized mental illnesses. Respondents were unlikely to believe these individuals were violent, and they were more willing to interact with them. Of all the disorders, respondents were most willing to work with the character with PTSD or have him or her marry into their family.

- The lack of stigma for PTSD and elderly depression may be related to respondents' tendency not to view them as mental illnesses. As previously discussed, many respondents felt the elderly depression characters' symptoms were a result of physical illness and old age, and many also seemed to feel the character with PTSD was not mentally ill, but instead acting normally to stressful circumstances.

- Because most respondents did not view the vignette character with PTSD as suffering from "mental illness," data regarding people's beliefs about the schizophrenic individual (who was widely believed to be mentally ill) is most likely the best indicator of respondent attitudes towards individuals with mental illness in general.

Treatment of Mental Illness

- Consistent with other data on stigma, respondents were least likely to believe that schizophrenic individuals were able to make decisions regarding their own treatment, least likely to believe they would improve on their own, and most likely to believe they should be forced into treatment.
    - In contrast, respondents were more likely to feel that individuals with PTSD were able to make their own money and treatment decisions, more likely to believe they would improve on their own, and least likely to believe they should be forced into treatment.

- Lower educated individuals and males were more likely to believe that the character should be forced into treatment, especially if the character was schizophrenic or male. This may have to do with the perceived dangerousness of male mentally ill individuals.
    - However, almost all respondents felt a mentally ill individual, regardless of type of illness, should be forced into treatment if he or she was dangerous to others.

- Finally, individuals with less education, males, and those in urban areas were less likely to believe the characters' condition would improve with treatment.

Policy Implications

General

- Overall, targeted educational campaigns toward persons living in rural and urban areas, males, older persons (65 or older), and those with less formal education or less personal experience with mental illness might yield more productive results than a general educational campaign. The educational campaign should focus on how to recognize the signs of mental illness among friends and family, and also convey that mental illness is a serious illness, not the result of weakness or a character flaw.

Although rural and urban residents were less knowledgeable about mental illness, they were more willing than suburban residents to be willing to interact with mentally ill individuals.

- Although rural and urban residents were less knowledgeable about mental illness in general, individuals in suburban areas (particularly males over age 50 and all individuals over age 65) were less likely to be willing to interact with mentally ill individuals. Therefore, anti-stigma messages that encourage contact with the mentally ill should be targeted towards males, the elderly, and those in suburban areas of the state, particularly those in St. Louis county and Greene county.

- The results of the survey suggest the perception that the mentally ill are dangerous is pervasive across all regions and demographics. Therefore, messages that debunk myths regarding the dangerousness of mentally ill individuals (particularly those with Schizophrenia) should be focused throughout the state.

- Less educated individuals, males, and those in urban areas were least likely to believe the characters' condition would improve with treatment. Therefore, males and those in urban areas may serve as good targets for messages regarding the effectiveness of mental health treatment.

Knowledge

On the whole, individuals with more familiarity with and education about those with mental illness were more accepting of people with mental illness, perceived them as less dangerous, and felt they could improve with treatment.

- Education appears to be one major driving force behind stigma. On the whole, individuals who have more familiarity with and education about those with a mental illness were more accepting, perceived them to be less dangerous, and felt they could improve with treatment. These findings suggest that additional education to those less knowledgeable and familiar can help to reduce stigma.

- PTSD is perceived less to be a mental illness and more a normal result of stress. More education to the general public regarding the link between PTSD and mental illness is recommended**.**

- Elderly depression is perceived by many to be physical illness or a normal response to aging, rather than a mental illness. Depression among the elderly is the result of several factors, including fears of death, repeated loss/bereavement, loneliness and isolation, and the lack of an adequate support system. Perceiving elderly depression to be a normal response may lead to a lack of response on the part of elderly persons who need help and their families and caretakers. Messages that convey this is a treatable disease may result in increased well-being for a large segment of Missouri's population.

Stigma

- Although education is one driving force behind stigma, our results strongly suggest education alone is not enough to reduce mental illness stigma.

Education alone is not enough to reduce mental illness stigma.

  - Those from suburban areas and those with higher income (groups which generally tend to be more educated) were least willing to interact with a mentally ill individual in intimate situations, such as working closely with them, or having them marry into their family.
    - This suggests there may be some social class-based stigma attached to mental illness.
  - Furthermore, the fact that perceived dangerousness of the mentally ill is one of the best predictors of stigma suggests that while increased education will probably reduce stigma for some people, it may not be sufficient for others.
  - Overall, the data suggests that while educational messages should be focused in rural and urban areas, anti-stigma messages should be focused throughout the state.

- Anti-stigma messages suggesting that mental illness is not an indication of weakness may go a long way towards reducing stigma in males. However, this will have to be suggested in such a way that does not undermine messages that encourage the public to view the mentally ill as less violent.

Messages suggesting that mental illness is not weakness may help reduce stigma in males.

- Schizophrenia and MDD were most stigmatized; people were least likely to want to interact with persons afflicted with them, especially if they were men. Education regarding these illnesses, particularly targeted to men (especially those over age 50), males and females over age 65, and those living suburban areas might be helpful to reduce stigma.
  - Some education about the actual rates of suicide/violence among these disorders is recommended. While some persons with schizophrenia can be violent to others, the vast majority are not; persons with personality disorders and substance abuse problems tend to be far more violent. (Angermeyer, 2000).

- Males were less willing than females to work closely or have someone in the family marry the vignette character.

- Upper income males (with households making more than $100,000 a year) were the least willing to have someone with mental illness marry into their family.

- 80% of males making less than $20,000 a year would be willing to work with someone with a mental illness compared to only 36% of males making $100,000 or more. Differences were less pronounced among more educated males.

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Treatment

- Generally, those with more formal education, females, and individuals living in suburban areas were most accepting and optimistic about treatment. Targeted campaigns that present information on the effectiveness of treatment is recommended for less educated individuals, males, and persons living in urban or rural areas.

- Individuals felt that both physical and mental heath care should primarily be paid for by Medicaid or Medicare. This suggests public support for funding those with mental illness. Presenting this information to politicians and policy makers regarding mental health care funding is suggested.

- One of the main reasons people didn't seek treatment was because they felt it was too expensive. This reason was slightly more common in lower income respondents. Therefore, education regarding area mental health resources for those with no health insurance or limited financial means may encourage those who feel they cannot afford treatment to get help.

- Finally, the data suggests that higher income respondents may see mental illness as a problem of the poor. This is an important stigma issue: educational messages should emphasize that mental health is an issue regardless of socioeconomic status.

Definition and Sources of Information Regarding Mental Illness

- Respondents learned the most from knowing someone with mental illness. Individuals who know someone with mental illness were least likely to stigmatize the mentally ill. This suggests that the most successful educational messages will be as realistic as possible, perhaps featuring real individuals with mental illness.

- Messages should further encourage the broadening of the definition of mental illness that is already taking place, while also conveying the seriousness of mental illness.

- Our results suggest that mental illness campaigns have been successful at reducing mental illness stigma, although less effective at (or perhaps less focused on) educating individuals about mental illness. This underscores the need for an effective educational intervention.

Conclusion

Mental heath stigma in Missouri persists despite dramatic improvements in recent years. Data indicate that certain mental illnesses, those that people know less about, are more likely to be stigmatized than more familiar illnesses. Those who think that persons with mental illness are dangerous, especially those less familiar with these illnesses, are most likely not to want to associate with persons with mental health problems. Furthermore, distinct demographic groups are more stigmatizing than others, with the most stigma generated from older males and the elderly, particularly those in suburban areas. Future policies and actions taken regarding mental illness should address these differences and plan specific strategies that are appropriate to each illness and to the individuals most likely to stigmatize those with mental illness.

DETAILED RESULTS

METHODS

In Summer 2006, 1,001 adults 18 years of age and older living in households throughout Missouri were randomly surveyed. Survey questions came from the General Social Survey, a national survey used by the Indiana Consortium for Mental Health Services Research to gain information about American views of mental health (Pescosolido et al., 2000). Some questions were removed, and others were modified to fit the requirements of the current survey. Researchers at the Missouri Institute of Mental (MIMH) were responsible for the design of the survey and data collection plan. In theory, with a probability sample of this size, one can say with 95% certainty that the results for the overall sample have a sampling error of plus or minus 1% of what they would be if all Missourians had been polled with complete accuracy. Unfortunately, there are several other possible sources of error in all polls or surveys that are probably more serious than theoretical calculations of sampling error. They include refusals to be interviewed (non-response), question wording and question order, interviewer bias, weighting by demographic control data and screening. It is impossible to quantify the errors that may result from these factors. However, the following measures were taken to increase sampling accuracy:

- The questionnaire was developed by MIMH from pre-existing questions that had been tested on a national sample.
- A list-assisted random-digit dialing method was used to assure that unlisted and listed number had an equal chance of being selected.
- A phone number list was generated and respondents were required to call back the selected number at different times during the day and on weekends until they reached someone in that household.
- Interviews were conducted by the Health and Behavioral Risk Research Center (HBRRC) at the University of Missouri-Columbia, a unit that specializes in survey research.
- The unit uses professional, trained interviewers who are supervised at all times by an experienced telephone survey supervisor.
- Computerized telephone software (Ci3) is used to minimize data errors and assure proper skipping of questions where needed.
- Respondents were required to rotate the type of respondent they asked for when they made their calls to assure that they did not get only middle-aged to older women, who more typically answer the telephone.
- Data were weighted statistically to account for differences in the telephone sample and Missouri demographic statistics.

The survey was administered by the HBRRC at the University of Missouri-Columbia. The survey took approximately 15 minutes to complete by telephone. Respondents were informed that they could refuse to answer any question in the survey.

Survey Content

The survey explored a variety of issues related to mental health stigma, including causes of mental illness, association with persons with mental illness, treatment, and perceived danger among those with mental illness (See Appendix A for the survey).

Each respondent was read a vignette about a person with a particular mental illness and asked a series of questions regarding the characteristics of that person and their illness. No one was specifically told that their "vignette character" had a specific mental illness, only the symptoms of the illness (see Appendix D for the vignettes). There were 200 respondents per each of the five diagnoses [schizophrenia, bipolar disorder, major depressive disorder (MDD), elderly depression and post traumatic stress disorder (PTSD)] for a total of 1,000 participants. Because of the need to adequate address their mental health needs, approximately 200 surveys of African-Americans were conducted; slightly more than the percentage represented in the general adult population Missouri.

Subgroup Analysis

Analyses were conducted on the total population and according to different subgroups. The primary subgroups and the description of how they were categorized are described below.

- **Age:** was divided into four categories, representing young adulthood (ages 18-33), middle age (34-49), late adulthood (50-64), and old age (65 and older).
- **Gender:** The options were male, female, or "other." No respondents chose the "other" category.
- **Ethnicity:** Respondents were given the following options: Hispanic, American Indian or Alaskan Native, Black or African-American, White, or "Other."
- **Education:** Respondents chose from the following options: 8^{th} grade or less, some high school, high school graduate, GED or high school equivalent, some college, Bachelor's Degree, Master's Degree or Professional/Doctoral Degree.
    - For purposes of data analyses, the options were combined to make four categories: Some high school or less, high school diploma or GED, some college or a Bachelor's degree, and graduate or professional degree.
- **Area Type:** Respondents were asked whether they consider themselves to live in either a rural, urban, or suburban area.
- **Missouri Region:** respondents were asked which county they live in and their zip code. This information was used to place them in one of the following Missouri regions: Boone County, Clay County, Greene County, Jackson County, Jefferson County, St. Charles County, Cit of St. Louis, St. Louis County, or "other."
- **Income:** Respondents were given the following options for income: less than $20,000 a year, $20,000-$34,999, $35,000-$49,999, $50,000-$74,999, $75,000-$99,999, $100,000 or more.

Data Analyses

Analyses of the main effects were performed primarily using one-way analyses of variance (ANOVA). Further analyses were done using ANOVA and analyses of covariance (ANCOVA) to detect complex interactions. Chi-square, descriptive statistics and crosstabs were also used to explore complex group differences and for descriptive purposes.

Demographics

Demographics for the sample are shown in Table 1, pg. 15. African-Americans were intentionally over-sampled to ensure enough individuals to draw conclusions. Females were unintentionally over-sampled. To account for these, the data were weighted for most analyses to approximate the distribution of race and gender in the Missouri population. The weights were removed only for the analyses of race and gender.

Table 1.
Demographics of the Sample (n=1,001)

	Frequency	Percent
Age		
18-33	161	16.8%
34-49	246	25.6%
50-64	301	31.3%
65 and older	253	26.3%
Gender		
Male	379	37.9%
Female	622	62.1%
Ethnicity		
African-American	225	22.5%
American Indian/Alaskan Native	16	1.6%
Asian/Pacific Islander	6	.6%
Hispanic	24	2.4%
Other	24	2.4%
White	703	70.4%
Missouri Region		
Boone (Columbia)	21	2.1%
Clay	27	2.7%
Greene (Springfield)	38	3.8%
Jackson (KC)	165	16.6%
Jefferson	25	2.5%
Other	401	40.3%
St. Charles	36	3.6%
City of St. Louis	103	10.4%
St. Louis County	178	17.9%
Education		
Some High School or Less	102	10.2%
High School Diploma or GED	315	31.6%
Some College or Bachelor's Degree	488	48.9%
Graduate or Professional Degree	93	9.3%
Area Type		
Urban	377	38.2%
Suburban	300	30.4%
Rural	310	31.4%
Income		
Less than $20,000/year	204	23.6%
$20,000-$34,999/year	182	21.0%
$35,000-$49,999/year	167	19.3%
$50,000-$74,999/year	170	19.6%
$75,000-99,999/year	60	6.9%
More than $100,000/year	83	9.6%

Survey Findings

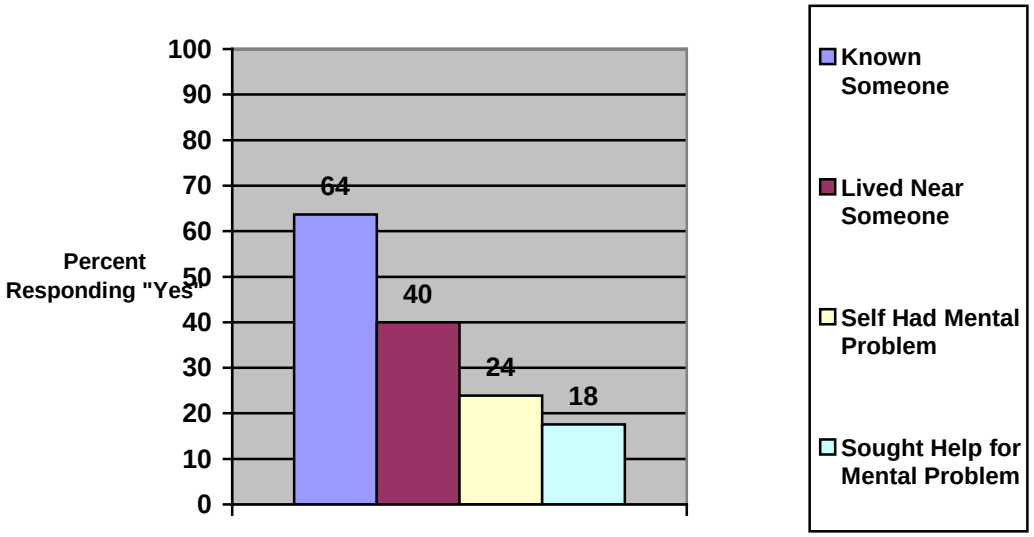
PERSONAL EXPERIENCE WITH MENTAL ILLNESS

Respondents were asked about their own experiences with mental illness. Items asked whether the respondent had 1) known someone with a serious mental illness, 2) lived near someone with a serious mental illness, 3) ever felt that he or she had a mental health problem, and (if said yes to #3), 4) ever sought help for his or her mental health problem. Those who said they've had a mental health problem and never sought help were also asked their reasons for not seeking help. Those who have sought help were asked whether the treatment helped and from whom they received services.

See Figure 1 for results. A large proportion of respondents reported knowing (63.7%) or living near (40%) someone with a mental illness at some time. When asked who they knew, around one-quarter said a close family member.

Approximately one-fifth of Missourians sampled reported having a mental health problem of their own, and around three-quarters (73.7%) who reported having a mental health problem (or 17.6% of the total sample) had sought help for a mental illness. A larger percentage of women than men reported having a mental health problem.

Figure 1.
Respondent's Personal Experience with Mental Illness



Feelings about Treatment

- The largest number of respondents sought help from a psychologist, but a number of respondents reported seeking help from a psychiatrist or a general practitioner. (See Table 2). Most respondents (88.3%) said that the treatment had helped. More respondents who had seen a psychiatrist or general practitioner reported that the treatment helped than those who had seen a psychologist.

Table 2.
Service Providers (Based upon Number of Respondents who had Received Treatment)

	Number	**Percent**	**Did the Treatment Help? (% Yes)**
Psychologist	55	31.7%	75.9%
Psychiatrist/Psychoanalyst	36	21.0%	86.5%
General practitioner/Family doctor	40	22.9%	100%
Social worker/Therapist	13	7.4%	92.3%
Minister/Clergy	2	.9%	100%
Friend/Family	4	2.0%	100%
Other	24	14.1%	92%
Total	**175**	**100%**	

Reasons for Not Seeking Help

Respondents who experienced a mental health problem were asked if there was "ever a time in the last 12 months when you felt that you might need to get help for a mental health problem, but you didn't get help?" Most (88.3%) said "yes" to that question. The most common reasons for not seeking help were that 1) they felt they could handle it themselves, and 2) it was too expensive to get treatment. Many also felt the problem would get better by itself. (See Table 3, pg. 18).

Table 3.
Reasons for not Seeking Help

	% Yes
I think I can handle these kinds of problems on my own.	68.3%
It was too expensive.	61.2%
I thought the problem would get better by itself.	54.2%
My health insurance would not cover this kind of treatment.	39.6%
I don't have health insurance	14.6%
It would take too much time.	31.3%
I was unsure about where to go.	28.6%
Other (specify).	22.4%
I went in the past but it did not help.	21.7%
Help probably would not do any good.	21.3%
I was concerned about what others might think.	18.8%
I didn't want others to know.	18.4%
I didn't have the transportation	12.2%

A greater proportion of those who wanted treatment in the last 12 months, but did not get it had lower household incomes. Furthermore, those who felt the treatment was too expensive had slightly lower income than those who did not site expense as a reason for not seeking treatment. Those who felt they could handle it on their own tended to be male and higher income individuals

Interestingly, those who felt they could handle it on their own were also more likely to say that Medicaid or Medicare should fund mental health care. These data, coupled with the fact that males and those with higher incomes were more likely to say they could handle their issues on their own, suggest that higher income people may perceive more severe mental illness to be an issue among poorer people rather than individuals in higher income brackets. This is a critically important stigma issue; mental illness needs to be seen among all groups as an illness that exists regardless of income. Furthermore, greater mental illness stigma in higher income individuals may discourage these individuals from seeking help.

Summary: Personal Experience with Mental Illness

The results suggest that a majority of Missourians have had some personal experience with mental illness. Furthermore, the findings for treatment are promising. Findings indicate that a large proportion of those who have felt like they had mental illness (73.7%) sought help, and of those that sought help, a large majority believe the treatment helped (88.3%).

Still, as promising as those numbers are, approximately one-fourth of those who felt they had a mental health problem did not seek treatment. Main reasons given were: 1) because they felt able to handle the problem on their own and 2) that treatment was too expensive.

- Those who wanted help in the last 12 months but did not get it were more likely to have lower income.
- Men and individuals with higher income were slightly more likely to say they did not get help because they could handle the problem on their own.
- Those who felt the treatment was too expensive had slightly lower income than those who did not cite expense as a reason for not seeking treatment.

The data also suggests that individuals with higher income may see mental illness as a problem of the poor. This is a critically important stigma issue; mental illness needs to be seen among all groups as an illness that exists regardless of income. Furthermore, greater mental illness stigma in higher income individuals may discourage these individuals from seeking help.

CAUSES OF MENTAL ILLNESS

Respondents were asked a series of questions related to their beliefs about the causes of mental illness. Items asked how likely they felt that the illness described in the vignettes (MDD, PTSD, schizophrenia, bipolar disorder, and depression in the elderly)were the result of 1) a bad character; 2) a chemical imbalance; 3) how they were raised; 4) stressful circumstances, 5) genetics; 6) a higher power, and 7) aging.

Overall, respondents felt the most likely reasons for the illness described in the vignette were stressful circumstances (83.7%) and a chemical imbalance (78.8%). (See Table 4). The majority also felt that genetics were a likely cause (61.9%).

Table 4.
Perceived Cause of Vignette Character's Disorder

	Bad Character	**Chemical Imbalance**	**How Raised**	**Stressful Circumstances**	**Genetics**	**Higher Power**	**Aging**
Very Likely	11.5%	**40.9%**	7.6%	41.7%	18.7%	8.8%	15.0%
Somewhat Likely	18.6%	37.9%	27.4%	**42.0%**	**43.2%**	13.5%	32.3%
Somewhat Unlikely	19.9%	11.1%	24.1%	7.8%	17.7%	20.5%	17.5%
Very Unlikely	**50.1%**	10.1%	**40.9%**	8.5%	20.4%	**57.3%**	**35.1%**
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

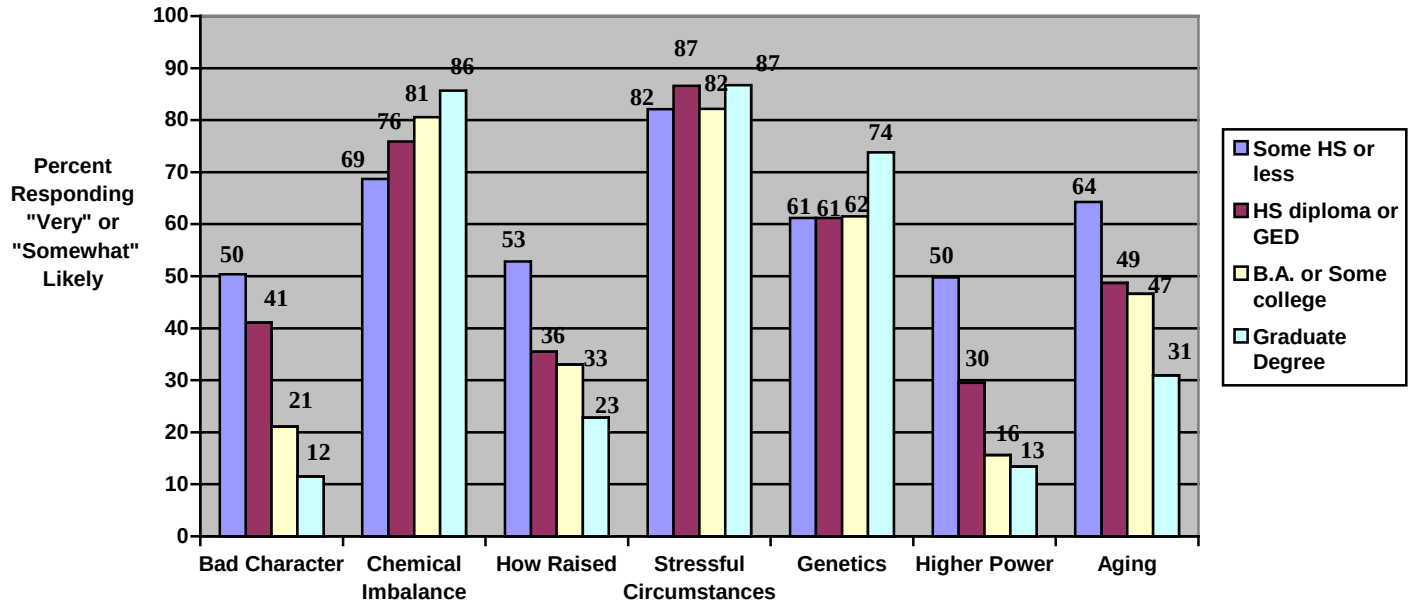
Age

Respondents, ages 50-64, were most likely to endorse that mental illness is a result of a higher power, and least likely to believe that it is a result of how you were raised. Those aged 65 and older were most likely of all age groups to endorse that it is a result of bad character. This finding did not change when differences in education were taken into account. Once again it should be noted that bad character and a higher power were considered unlikely causes overall, by all age groups. Other than the aforementioned, there were no significant differences by age.

Education

Most respondents of all educational levels believed that the mental illness described was the result of stressful circumstances. Not surprisingly, those with a higher educational level were more likely to also say that the mental illness described was the result of a chemical imbalance and genetics, although more than 60% of all groups felt an imbalance and genetics were contributors to mental illness. Those with less education (some high school or less) were also likely to say that the mental illness was also the result of bad character, aging, a higher power, or how you were raised. (See Figure 2).

Figure 2.
Perceived Cause of Mental Illness by Educational Level: % Who Responded "Very Likely" or "Somewhat Likely"



Type of Mental Illness

There were significant differences in beliefs regarding the causes of mental illness based upon the type of disorder described to respondents (See Figure 3, pg. 22-23). Those who were read the elderly depression vignette believed that aging was the most important cause of the character's difficulties, those who read the schizophrenia vignette believe a chemical imbalance was the most likely cause, and those with the MDD, bipolar, and PTSD vignettes believed stressful circumstances were the most likely cause. Whereas those with the MDD and bipolar vignettes also believed genetics and a chemical imbalance played a strong role, those with the PTSD vignette they played less of a role, and that stressful circumstances was by far the most important cause. Furthermore, while aging was perceived as most important in elderly depression and a chemical imbalance was perceived as most important in schizophrenia, respondents believed genetics and stressful circumstances also playing in important role in causing both.

Area Type

Respondents in urban and rural areas were significantly more likely than those in suburban areas to see mental illness as a result of bad character, although it should be noted that all areas felt it was an unlikely cause overall. Those in urban areas were more likely than those in suburban areas to attribute mental illness to a higher power or how you were raised. Again, however, all geographic areas considered these unlikely causes.

Vignette Character Gender

The gender of the character in the vignette also affected respondents' attributions. In the vignettes with male characters, mental illness was significantly more likely to be considered a result of bad character, whereas the mental illness of female characters was more likely to be attributed to stressful circumstances and aging.

Respondent Gender

Male respondents were significantly more likely than females to believe that mental illness was the result of bad character or how you were raised (once again, low frequency responses overall for both genders). Females were more likely than males to believe mental illness is the result of a chemical imbalance. Overall, though, chemical imbalance was a high frequency response for both males and females.

Personal Experience with Mental Illness

Those who either A) knew someone with a mental illness B) lived near someone with a mental health problem C) felt they had a mental health problem themselves or D) sought help for a mental health problem were significantly less likely (than those who did not endorse A, B, C, or D) to believe that mental illness was a result of bad character and they were significantly more likely to believe it was a result of a chemical imbalance (compared to those who did not endorse A, B, C, or D). Those who had a mental problem and had sought help were less likely to believe mental illness was the result of either aging or a bad character. Genetics were also perceived to be more important among those who knew or lived near someone with a mental illness.

Figure 3.

Perceived Cause of Mental Illness by Type of Disorder: Percent of Respondents in Each Vignette that Endorsed "Very Likely" or "Somewhat Likely"

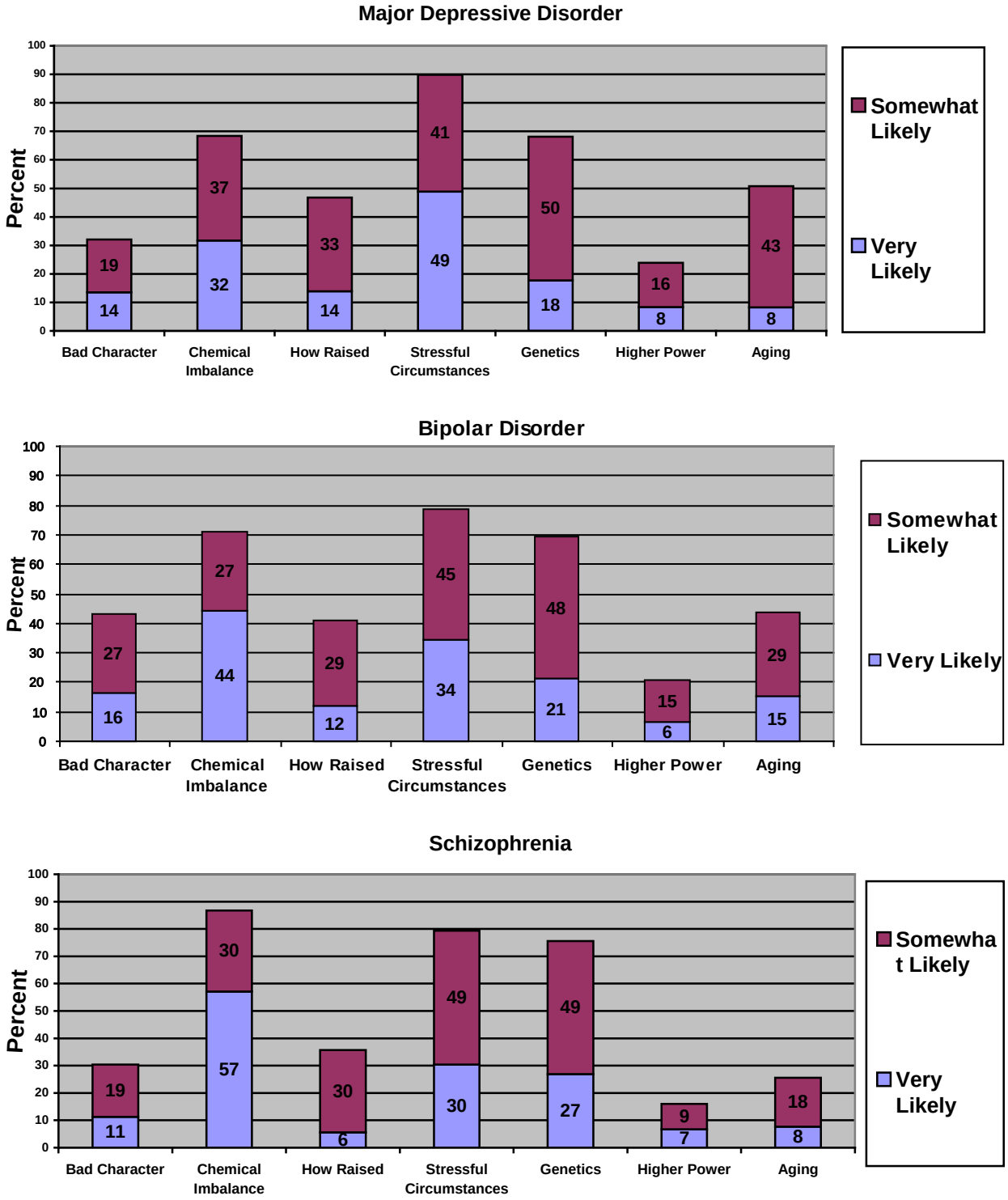
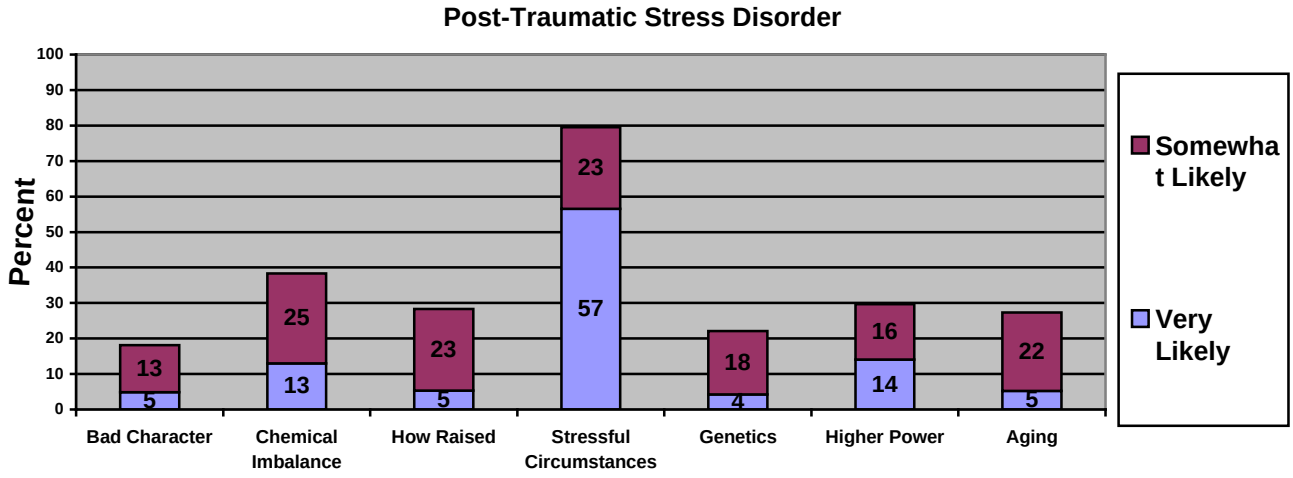
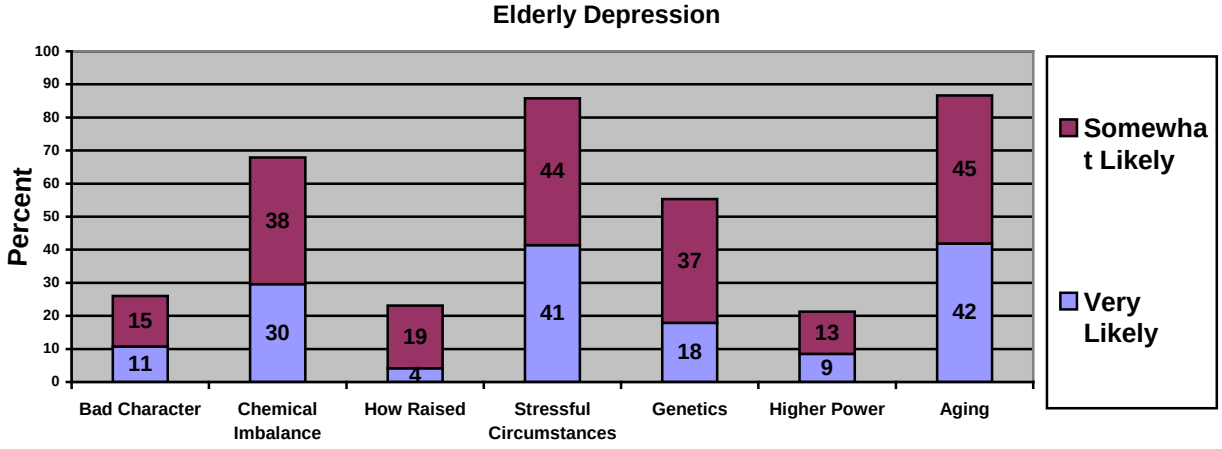


Figure 3 Continued.

Perceived Cause of Mental Illness by Type of Disorder: Percent of Respondents in Each Vignette that Endorsed "Very Likely" or "Somewhat Likely"





Summary: The Causes of Mental Illness

- Data suggest that education (whether from formal sources or personal experience) is a driving force behind eliminating myths related to mental illness. Respondents with less education and less familiarity with mental illness were least knowledgeable about the causes of mental illness.

- Those in urban or rural areas, older adults, and males were more likely to feel mental illness was a result of bad character.
    - In terms of older adults and those in urban and rural areas, this finding is most likely at least partially the result of less education about the causes of mental illness in those groups. However, analyses suggest that education does not completely account for the difference.

- Since differences in income, ethnicity, and personal experience also do not account for the differences between urban, suburban, and rural respondents, it is likely the finding reflects a true geographic dissimilarity in attitudes about mental illness.
- Further analyses of older adults' tendency to attribute mental illness to bad character suggested that their opinions were not due to lower educational levels. Instead, their opinions may be the result of generational beliefs about mental illness.

o Why males in the sample were more likely to attribute mental illness to bad character is unclear. Since analyses of our sample indicate no gender differences in either formal education or personal experience with mental illness, it seems likely that our finding may be at least partially attributed to socialization that encourages males to be tough, independent, and under emotional control (Addis & Mahalik, 2003). Males may see those that fail to express these qualities as weak, or in the case of this sample, having "a bad character."

Men tended to attribute mental illness to bad character more than women. Socialization that encourages males to be tough, independent, and under emotional control may explain this difference (Addis & Mahalik, 2003).

RECOGNIZING MENTAL ILLNESS

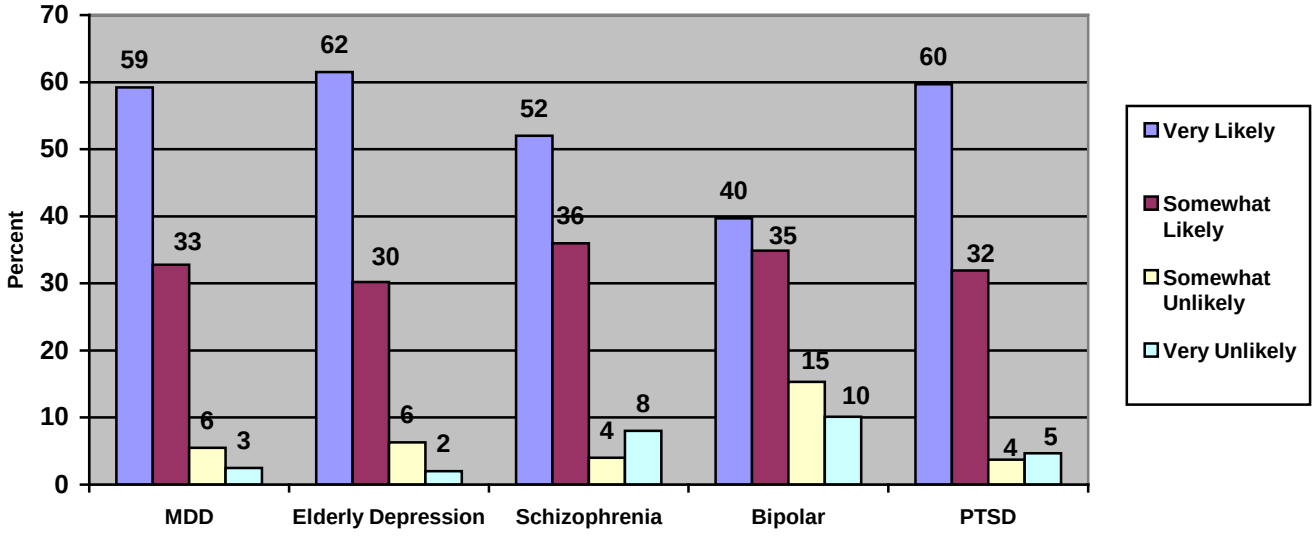
Respondents were asked a series of questions related to their beliefs regarding the experience of mental illness. Items asked how likely they felt that the character described in the vignettes were experiencing the following: 1) part of the ups and downs of normal life; 2) a nervous breakdown; 3) a mental illness, and 4) a physical illness. (See Table 5, pg. 26). A large proportion of respondents (69.7%) believed it was "very likely" or "somewhat" likely that the character in the vignette was experiencing mental illness. However, a large proportion of respondents also endorsed that the character is experiencing the normal "ups and downs" of life (58.9%). The results suggest it may have been difficult for the respondents to recognize the difference between normal behavior and mental illness.

Respondents were also asked how likely they felt that the character was experiencing the mental disorder described in the vignette (depending on the vignette, they were asked how likely the character was experiencing MDD, PTSD, schizophrenia, bipolar disorder, or depression in the elderly). For the most part, the respondents correctly recognized the mental disorder described in the vignette. (See Figure 4, pg. 26). Based on the percentage of respondents who believed it was very likely that the Individual was experiencing the illness described in the vignette, respondents were least likely to recognize bipolar disorder and schizophrenia, and most likely to recognize the depressive disorders.

Table 5.
Characterization of Symptoms of Mentally Ill Persons in Vignettes

	Normal Life	Nervous Breakdown	Mental Illness	Physical Illness
Very Likely	23.6	20.7	32.4	18.2
Somewhat Likely	**35.3**	**44.3**	**37.3**	**40.5**
Somewhat Unlikely	19.5	19	15.1	21.6
Very Unlikely	21.6	16.1	15.3	19.8

Figure 4.
Respondents' Perception of the Likelihood that the Vignette Character was Experiencing the Illness Described in the Vignette.



- Respondents were most likely to believe the character in the elderly depression vignette was experiencing physical illness.

- Schizophrenia and depression were most likely to be considered a "mental illness," whereas PTSD was least likely.

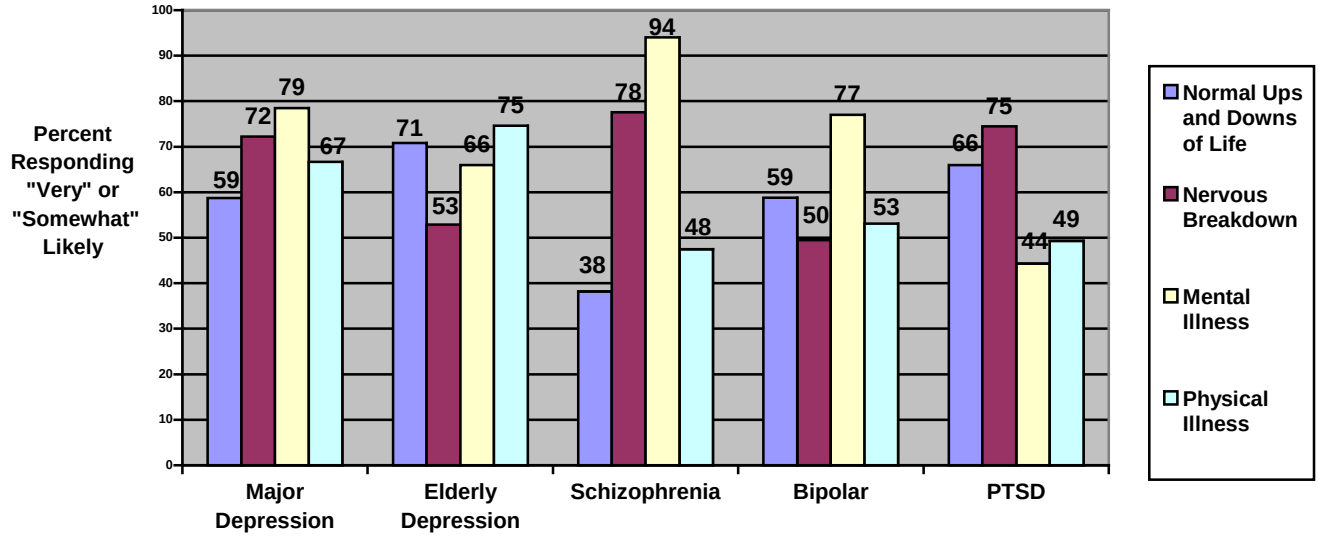
- Those with PTSD were most likely to be considered as experiencing a nervous breakdown.

- Those aged 65 and older were most likely to believe that the vignette character was experiencing the ups and downs of normal life, and those aged 34-64 were most likely to believe the character was experiencing mental illness. Younger individuals (aged 18-33) were least likely to believe the character was experiencing physical illness.

- Female vignette characters were more likely to be thought of as experiencing physical illness than the male vignette characters. Female respondents more likely than male respondents to believe the individual was experiencing mental illness. Overall, females were better at recognizing mental disorders than males, particularly PTSD.

- In terms of education**,** respondents with higher levels of education were less likely to believe the character described in the vignette was experiencing a nervous breakdown or the ups and downs of normal life, and more likely to recognize the characters' problems as mental illness. (See Figure 6, pg. 28). Those with a graduate degree were also more likely than other groups to correctly recognize PTSD and bipolar disorder, and those with some high school or less were significantly less likely to correctly recognize Schizophrenia than other educational groups. No educational groups had difficulty recognizing the depressive disorders.

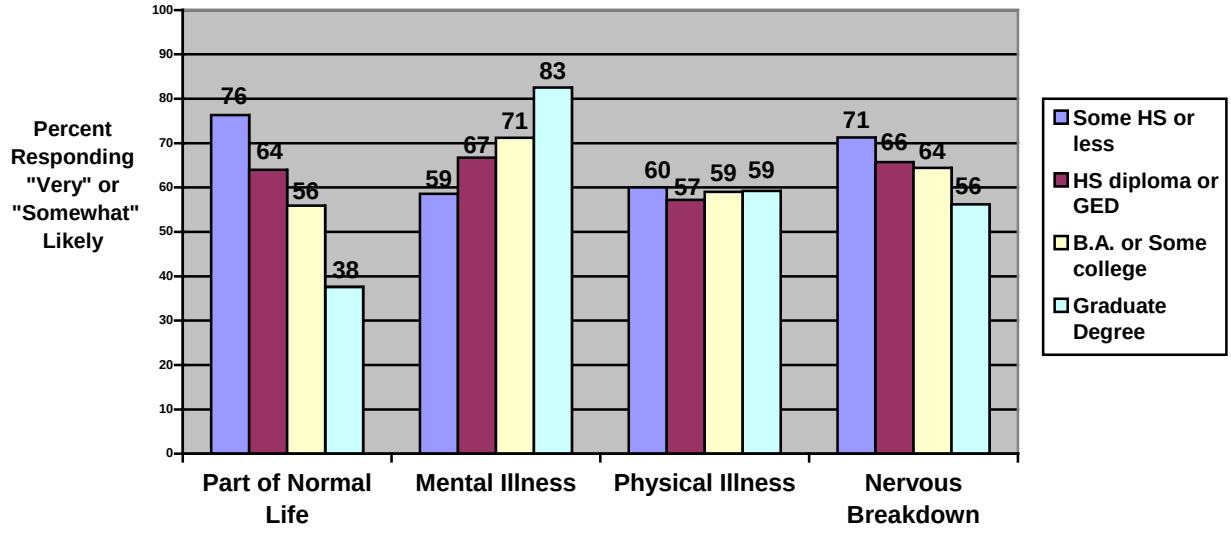
Figure 5.
Characterization of Symptoms of Mentally Ill Persons by Vignette: Percent of Respondents that Endorsed "Very" or "Somewhat" Likely



- Those from suburban areas were less likely than those from rural and urban areas to endorse that the individual was experiencing part of normal life, and most likely to recognize that the individual was experiencing mental illness. There were no differences by Missouri region.

- Person who had personal experience with mental illness were more likely to believe that the character described in the vignette was suffering from it, and least likely to believe the character was experiencing the ups and downs of normal life. Those with personal experience with mental illness were also more likely to recognize bipolar disorder and the depressive disorders.

Figure 6.
Characterization of Symptoms of Mentally Ill Persons in Vignettes by Respondents' Educational Level: Percent of Respondents that Endorsed "Very" or "Somewhat" Likely



- Finally, there were no differences by race, except White respondents were significantly better at recognizing bipolar disorder than African-American respondents. While this difference did not disappear when differences in education were taken into account, it did disappear when differences in income were accounted for.

Summary: Recognizing Mental Illness

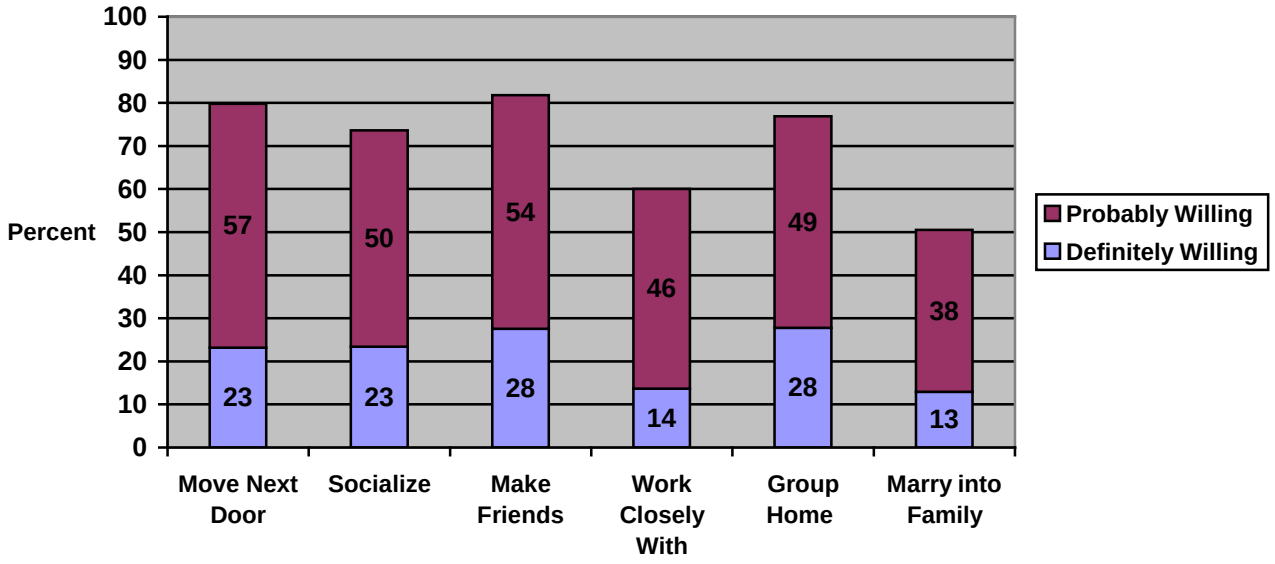
The results were similar to those for the causes of mental illness. Better educated persons, those in suburban areas, and females were better at recognizing the mental disorders, and more likely to recognize them as mental illnesses, not as a result of normal life or physical illness.

Notably, respondents were more likely to believe that individuals with elderly depression were experiencing normal life, and less likely to believe that individuals with PTSD were experiencing mental illness. These results may reflect a tendency to underestimate those two conditions as mental illnesses, and in the case of elderly depression, misattribute it as the result of the normal aging process. Overall, these results point to a need for adequate education regarding the seriousness of PTSD and elderly depression. Messages should stress that PTSD and elderly depression are not normal responses to stress or aging, and that these difficulties indicate the need for professional help.

THE STIGMA OF MENTAL ILLNESS

Respondents were asked a series of questions designed to address the stigma they attach to mental illness. One group of items asked how willing the respondent was to interact with the character described in the vignette in several situations, which varied in their level of intimacy. These included: 1) move next door to the vignette character, 2) spend an evening socializing with them, 3) make friends with them, 4) work closely with them on the job, 5) have a group home for people like the character in their neighborhood, and 6) have the character marry into their family (See Figure 7). Results indicate that respondents were most willing to make friends with the character (83% said "definitely" or "probably" willing), and least willing to work closely with the character (60% said "definitely" or "probably" willing) or have the vignette character marry into their family (only 51% said "definitely" or "probably" willing). The relatively low percentages of those "definitely willing" to interact with the vignette character suggest there is hesitation around associating with persons with mental illness, especially with regard to work and marriage.

Figure 7.
Percentage of Respondents "Definitely Willing" to Interact with the Person Described in the Vignette in Various Situations.



Of all the descriptions of mental illness, respondents who were read the schizophrenia vignette were significantly less likely than other respondents to want to interact with the vignette character in all areas assessed by the questionnaire. Respondents were most likely to be willing to interact with the characters in the PTSD and elderly depression vignettes. (See Figure 8, pg. 30-31). Respondents read the PTSD vignette were significantly more likely than other respondents to be willing to work closely with the character. They were also slightly more willing to have him or her marry into their family.

Figure 8.

Willingness of Respondent to Associate with the Vignette Character by Type of Mental Illness: Percent of Respondents in Each Vignette that Endorsed "Definitely" or "Somewhat" Willing

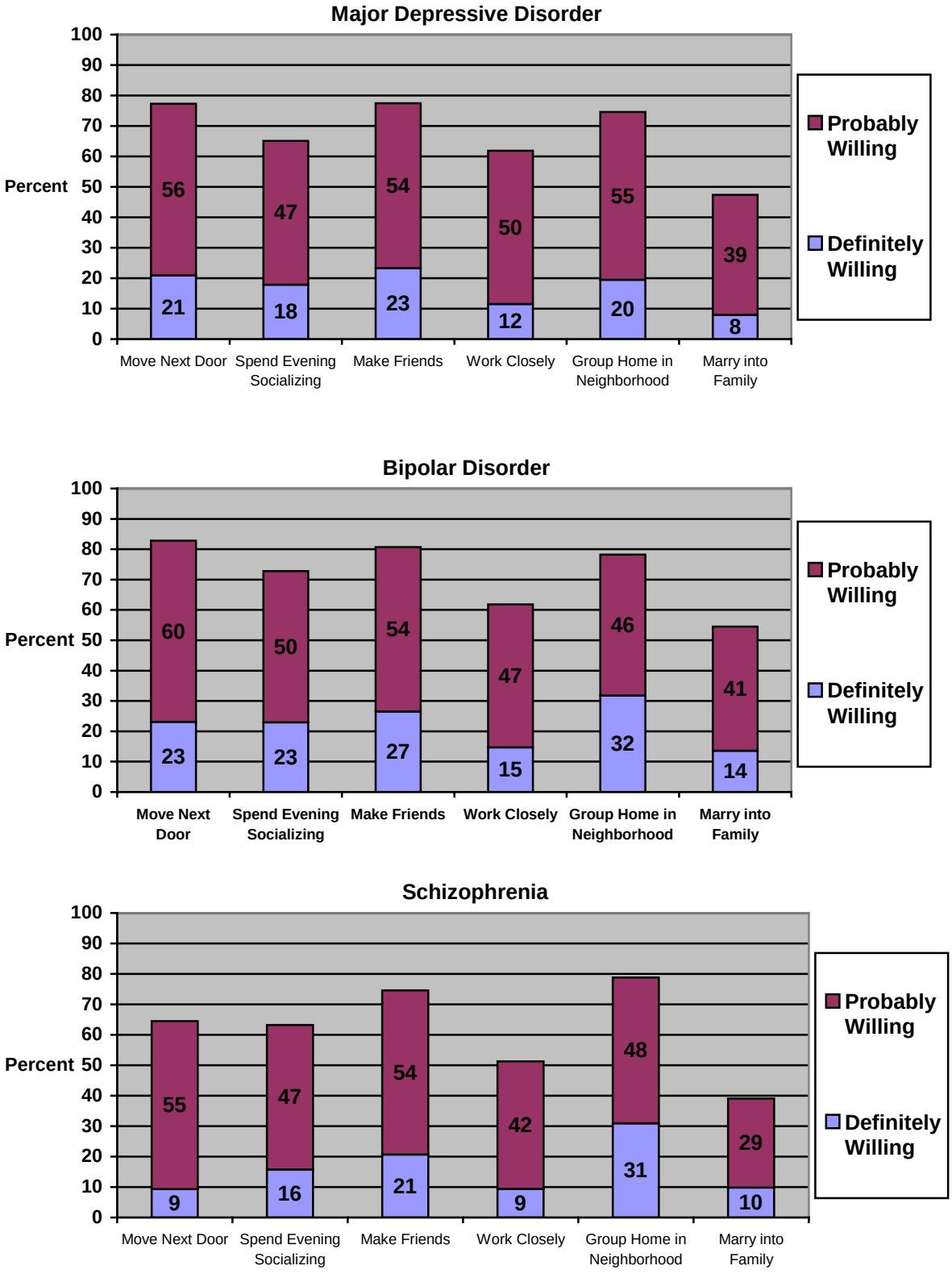
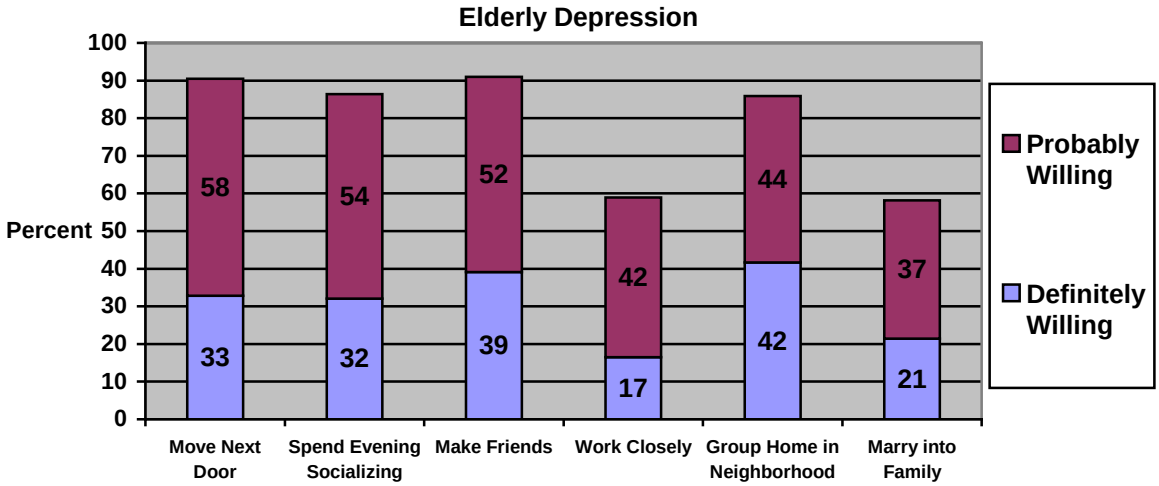
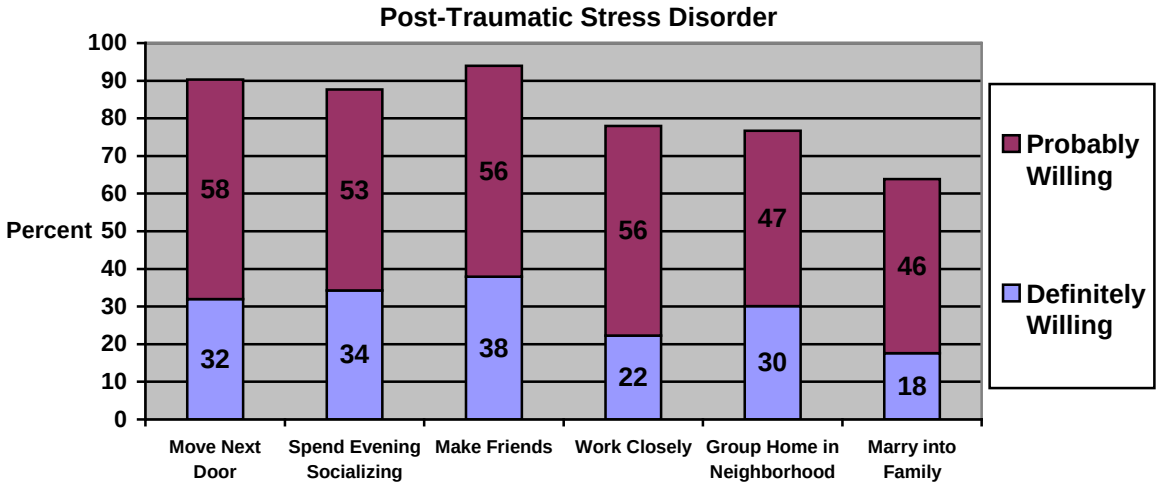


Figure 8 Continued.

Willingness of Respondent to Associate with the Vignette Character by Type of Mental Illness: Percent of Respondents in Each Vignette that Endorsed "Definitely" or "Somewhat" Willing





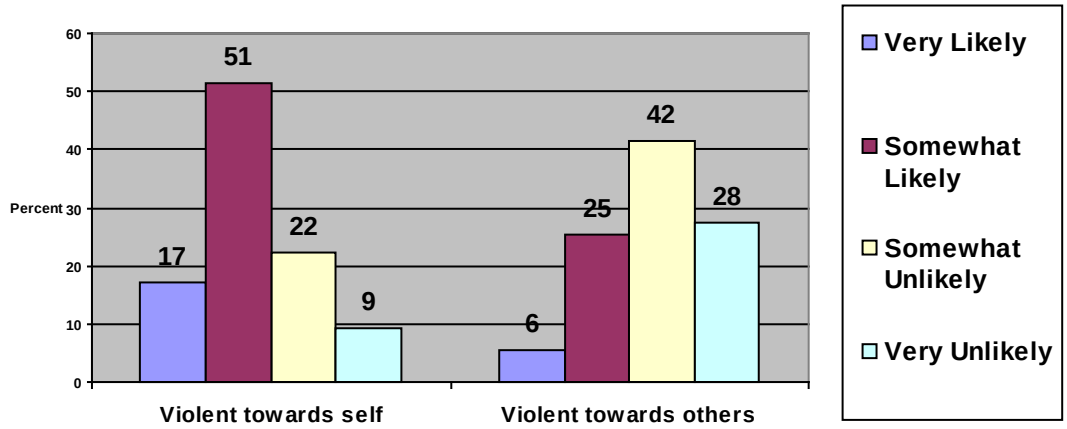
MENTAL ILLNESS STIGMA AND PERCEPTIONS OF DANGEROUSNESS

Respondents were asked how likely they felt the vignette character would be violent towards him or her, and how likely they felt he or she would be violent towards others. Results are shown in Figure 9. Respondents were much more likely to feel that person would be violent towards him or herself (68.4% said it was "very" or "somewhat" likely that the character would harm him or herself), than to feel the character would be violent towards others (30.9% said "very" or "somewhat" likely).

- Respondents felt the character in the Schizophrenia vignette was most likely to be violent towards him or her, followed closely by those with Major Depressive Disorder. However, a majority of respondents across all illnesses perceived their vignette character to be dangerous to themselves.

- Overall, respondents felt male characters were more likely to be violent towards both themselves and others. Those who have known someone with a mental illness or have experienced their own mental problem were significantly less likely (than those who have not known someone with or had a mental problem) to believe that the vignette character would be violent towards him or herself.

Figure 9.
Distribution of Responses Regarding the Vignette Character's Tendency to be Violent

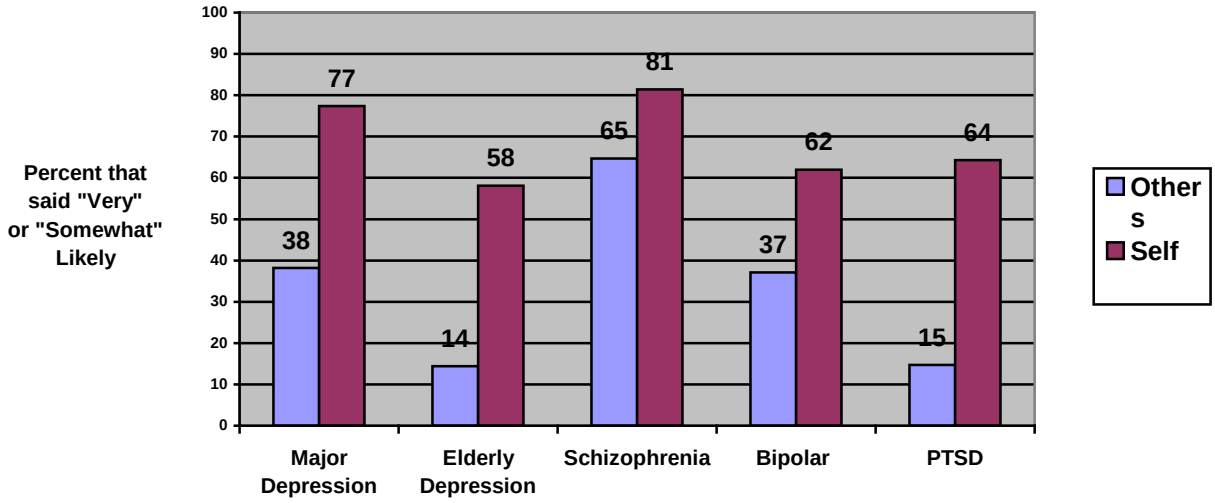


- Respondents felt the character in the schizophrenia vignette was most likely to be violent towards him or her, followed closely by those with MDD. However, a majority of respondents across all illnesses perceived their vignette character to be dangerous to themselves.

- The characters with schizophrenia were perceived to be more dangerous to others than other characters. The characters in the PTSD and elderly depression vignettes were considered least likely to be violent towards others. (See Figure 10, pg. 33).

- Overall, respondents felt male characters were more likely to be violent towards both themselves and others. Those who have known someone with a mental illness or have experienced their own mental problem were significantly less likely (than those who have not known someone with or had a mental problem) to believe that the vignette character would be violent towards him or herself.

Figure 10.
The Vignette Character's Tendencies to be Violent Toward Himself/Herself and Others



Mental Illness Stigma: Subgroup Differences

- Older people (65 and older) were much less willing to socialize with or have someone marry into their family than younger people. This finding held for both males and females.

Respondents least willing to interact with mentally ill persons tended to be older, male, higher income, and living in suburban areas. Those who perceived mentally ill people as violent were less likely to want to associate with them.

- Interestingly, while those in rural areas were less knowledgeable about the causes of mental illness, they were significantly *more* likely than those in suburban areas to be likely to socialize with, make friends with, and work closely with someone with a mental illness.
  - For instance, those in St. Louis and Greene counties (largely suburban areas) were significantly less willing than the other counties to socialize with the vignette character, make friends, or work closely with them.

- Males were less willing than females to work closely or have someone in the family marry the vignette character. Upper income males (with households making more than $100,000 a year) were the least willing to have someone with mental illness marry into their family. 80% of males

80% of males making less than $20,000 a year would be willing to work with someone with a mental illness compared to only 36% of males making $100,000 or more.

making less than $20,000 a year would be willing to work with someone with a mental illness compared to only 36% of males making $100,000 or more. Differences were less pronounced among more educated males.

- Overall, respondents were significantly more willing to allow a female than a male with mental illness move next door to them, have a group home in their neighborhood, and marry into their family. However, they were more willing to work closely with a male with mental illness than a female.

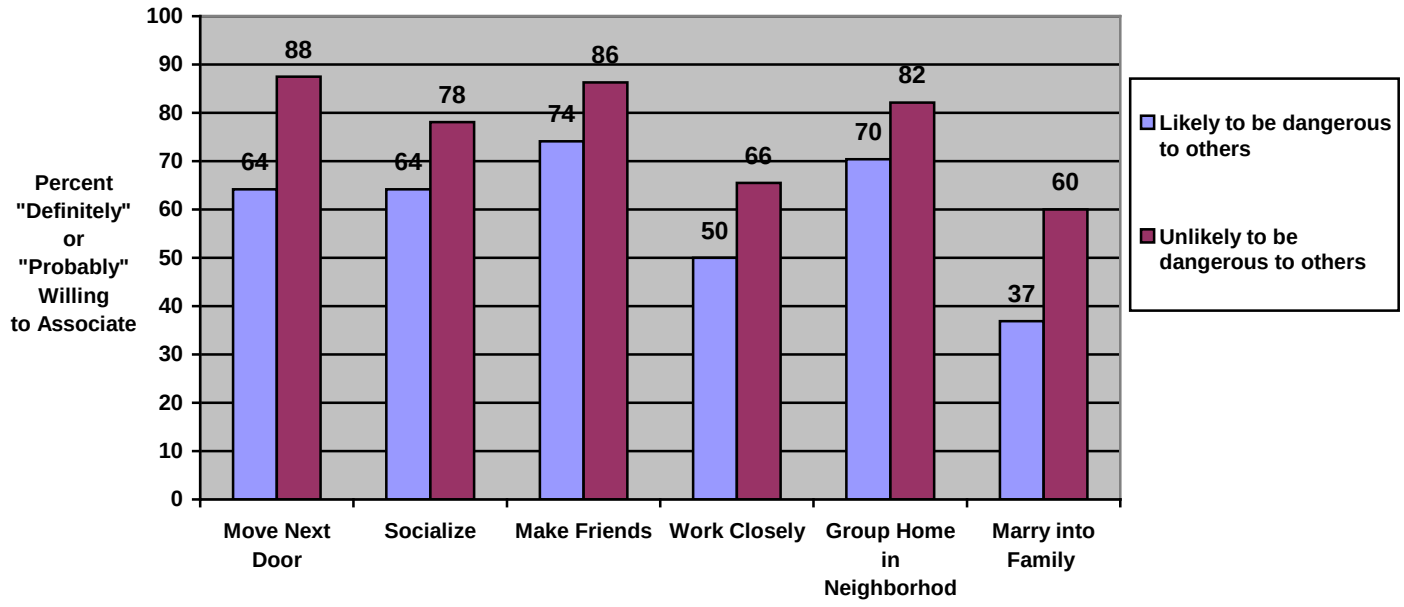
- Perception of dangerousness was one of the strongest predictors of whether respondents would associate with a vignette character. The perception that the vignette character might be dangerous to others made respondents much more unwilling to associate with them. (See Figure 11). This effect was most pronounced for allowing the character to marry into their family. The perception that the character might be dangerous to him or herself had a similar, albeit less powerful, effect.

The perception that the vignette character might be dangerous to others made respondents much more unwilling to associate with them.

- Those who perceived their vignette character as having a chemical imbalance were more willing to work with that character, but not have them marry into their family.

- There were no differences by race/ethnicity.

Figure 11.
Respondents' willingness to associate with the vignette characters based on their perception of the characters' dangerousness to others



Summary: The Stigma of Mental Illness

- Perceived dangerousness of the mentally ill is one of the best predictors of mental illness stigma. The results of the survey suggest the perception that the mentally ill are dangerous is pervasive across all regions and demographics. Only those with personal experience with mental illness were less likely to perceive the mentally ill as dangerous.
    - This suggests that while increased education will probably reduce stigma for some people, others will be less influenced by educational campaigns, particularly those who are fearful that persons with mental illness will be dangerous. Improving education regarding mental illness will not necessarily result in decreased stigma

- Although respondents in urban and rural have been shown to be less educated about the causes of mental illness, and less able to recognize mental illness, they were less likely than individuals in suburban areas to stigmatize a mentally ill individual. Stigma is also more common among the elderly and upper income males.

- Of the disorders, schizophrenia was by far the most stigmatized. Respondents viewed the schizophrenic character as very likely to be violent towards both him or her and others, and this effect was stronger if the character was male. Respondents were also least willing to interact with the schizophrenic character in all situations.

    While some persons with schizophrenia can be violent to others, the vast majority are not, while persons with personality disorders and substance abuse problems tend to be far more violent.

    - Results suggest that mental health programming designed to reduce stigma should focus on providing facts regarding the characteristics of persons with schizophrenia, particularly with regard to violence. While some persons with schizophrenia can be violent to others, the vast majority are not; persons with personality disorders and substance abuse problems tend to be far more violent. (Angermeyer, 2000).

- PTSD and elderly depression were the least stigmatized mental illnesses. Respondents were unlikely to believe these individuals were violent, and they were more willing to interact with them. Of all the disorders, respondents were most willing to work with the character with PTSD or have him or her marry into their family.
    - The lack of stigma for these mental illnesses may be related to respondents' tendency not to view them as mental illnesses. As previously discussed, many respondents felt the elderly depression characters' symptoms were a result of old age, and many also seemed to feel the character with PTSD was not mentally ill, but instead acting normally to stressful circumstances. Education is needed to ensure that PTSD and elderly depression are viewed as mental illnesses, not normal responses to old age or stressful circumstances.

THE TREATMENT OF MENTAL ILLNESS

Respondents were asked a series of questions related to their beliefs regarding the treatment of mental illness. Respondents were asked questions that addressed the following: 1) Ability of a mentally ill individual to make treatment and money decisions, 2) Likelihood that a mentally ill individual's situation would improve on its own or with treatment, 3) When and if an individual with mental illness should be forced into treatment, and 4) Who has responsibility for the cost of a mentally ill individual's treatment.

1) Treatment and Money Decisions

Respondent did not feel that their vignette character was very able to make either treatment or money decisions. Only 15.4% felt that their character was "very able" to make treatment decisions, and only 18.4% felt that their character was able to make financial decisions (See Table 6).

Table 6.
Frequency Distribution of Responses Regarding the Vignette Character's Ability to Make Decisions about Treatment and Money

	Treatment Decisions	**Money Decisions**
Very Able	15.4%	18.7%
Somewhat Able	48.4%	41.6%
Somewhat Unable	21.1%	25.2%
Very Unable	15.1%	14.6%

- Overall, respondents felt that the character was slightly better able to make his or her own decisions about the treatment he or she should receive (63.4% said very or somewhat able) than about his or her own money (60.3% said very or somewhat able)

- Older individuals were less likely than younger individuals to believe the character could make his or her own decisions about treatment and money. This finding coincides with the finding related to associating with the mentally ill. Older people have less education about the ability of those with mental illness to handle their everyday affairs as well as less information about the non-violent nature of most persons with mental illness.

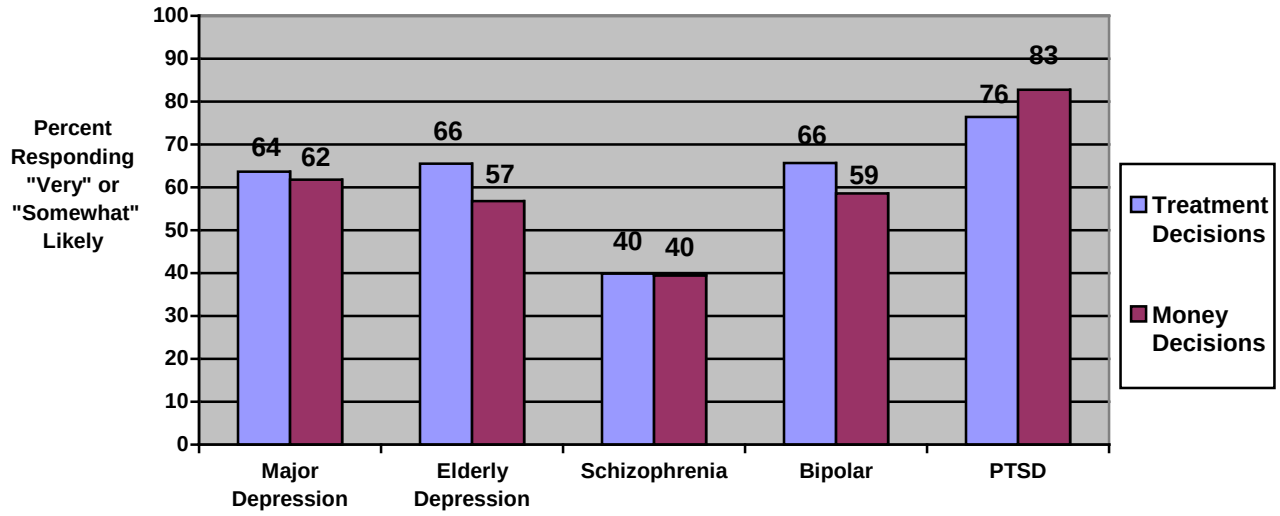
- Those with lower educational levels were also less likely to believe the character could manage his or her money.

- Males, while not wanting to associate with persons with mental illness as much as females, were more likely to believe that persons with mental illness could handle their own money.

- Interestingly, those who have lived near someone with mental illness in the past were less likely to believe the vignette character could make his or her own treatment decisions.

- Overall**,** schizophrenia vignette characters were seen as least able to make their own treatment and money decisions. PTSD vignette characters were seen as best able to make their own treatment and money decisions. (See Figure 12).

Figure 12.
Percent Responding that the Vignette Character was "Very" or "Somewhat" Able to Make His or Her Own Money Decisions



2) Likelihood of Illness Improving on Its Own

Respondents felt strongly that the character's situation would improve with treatment (93% said the character "very" or "somewhat" likely to improve with treatment) than without treatment (25.1% said the character was "very" or "somewhat" likely to improve on his or her own). See Table 7 for details.

Most respondents did not feel that their character's mental illness would improve on its own.

Table 7.
Likelihood that the Vignette Character's Condition would Improve on its Own or with Treatment

	Improve on its Own	**Improve with Treatment**
Very Likely	5.9%	**57.4%**
Somewhat Likely	19.2%	35.6%
Somewhat Unlikely	28.2%	4.3%
Very Unlikely	**46.7%**	2.6%

- Those with less education, males, African-American respondents, and urban respondents were more likely to believe the characters condition would improve on its own. However, the finding that African-American respondents are more likely than White respondents to believe the character's condition would improve on its own disappears when differences in education are taken into account. That is, less well-educated African-American and White respondents felt similarly that mental illness was likely to improve on its own.

- Middle-aged individuals (aged 34-64) and those with personal experience with mental illness were more likely to believe the character's condition would improve with treatment.

- Those who have sought treatment in the past and those who have known someone with mental illness in the past, were less likely to believe the character's situation would improve on its own

Those who have sought treatment in the past were less likely to believe the character's situation would improve on its own.

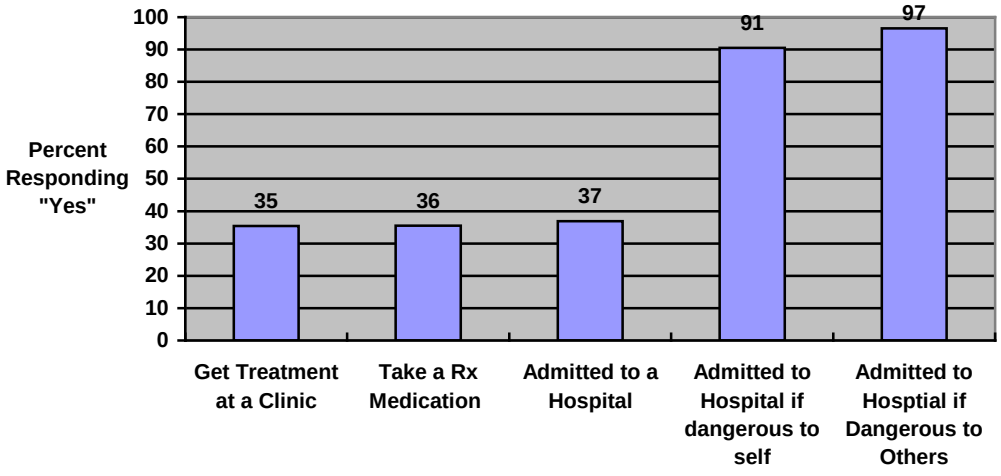
- Consistent with previous data, schizophrenia vignette characters were seen as least likely to improve on their own, and PTSD characters were seen as most likely to improve on their own.

3) Forced Treatment

- Most respondents (approximately 60-65%) felt that, under normal conditions, the vignette character should not be forced to get treatment at a clinic or doctor, take a prescription medication, or be admitted to hospital against his or her will. (See Figure 13).

- Nonetheless, almost all respondents felt that the character should be forced into admission at a hospital if the character was dangerous to his or herself (90.5%), or others (96.5%). This opinion was so universal, that there where no differences in opinion on these questions by any subgroup.

Figure 13.
Percent Responding that the Vignette Character Should be Forced into Treatment by Treatment Type

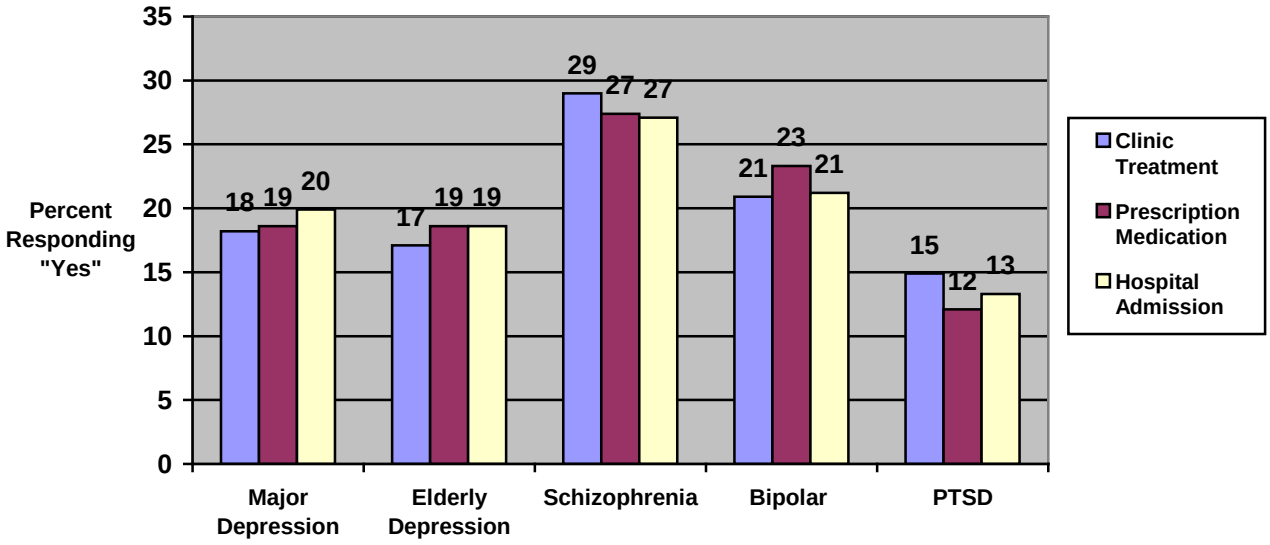


- Compared to other vignette characters**,** respondents were more likely to believe that Schizophrenia characters should be forced into all types of treatment (clinic treatment, medication, and hospital admission). (See Figure 14).

- Respondents aged 65 and older, those with less education than those in urban areas, males, and those with little personal experience with mental illness were more likely to believe that the character should be forced into all types of treatment.

- Respondents were more likely to believe the male vignette characters should be forced to get treatment at a clinic or doctor's office than female vignette characters.

Figure 14.
Percent Responding that the Vignette Character Should be Forced into Treatment by Treatment Type and Vignette.



4) Responsibility for Cost of Treatment

Most respondents felt that Medicaid or Medicare should have primary responsibility for both physical and mental health care costs.

Respondents were asked who should have primary and secondary responsibility for paying the cost of the vignette character's physical and mental health treatment. (See Table 8, pg. 40). Results did not differ for physical or mental health. Overall, most respondents (approximately 70-75%) felt that Medicaid or Medicare should have either primary or secondary responsibility for the individual's physical and medical healthcare. A sizable portion of respondents (approximately 45%) also felt the individual should take either primary or secondary responsibility for the cost of his or her physical and mental healthcare. While few respondents felt the family should have primary responsibility for the individual's physical and mental health (approximately 8%), a sizable number of respondents felt they should have secondary responsibility (approximately 26%).

Table 8.
Primary and Secondary Responsibility for the Character's Physical and Mental Health

	Most Responsible for Physical Health Care	Next Most Responsible for Physical Health Care	Most Responsible for Mental Health Care	Next Most Responsible for Mental Health Care
Character's Own Pocket	25%	22.7%	23.6%	20.4%
His/her Family	8.6%	**26.1%**	8%	26.6%
Employer	14.8%	15%	16.8%	11.5%
Medicaid/Medicare	**45.8%**	25.1%	**46.5%**	**28.7%**
Private Charity	5.8%	11.1%	5.1%	12.8%

- The greatest number of respondents across all mental illnesses felt that Medicaid or Medicare should pay for mental health care costs.

- Similar to physical health, respondents read the elderly depression vignette were more likely to believe Medicaid or Medicare should have primary responsibility for the character's mental health costs.

- Respondents read the MDD, schizophrenia, or PTSD vignettes were more likely to believe the employer should take primary responsibility for the character's mental health costs.

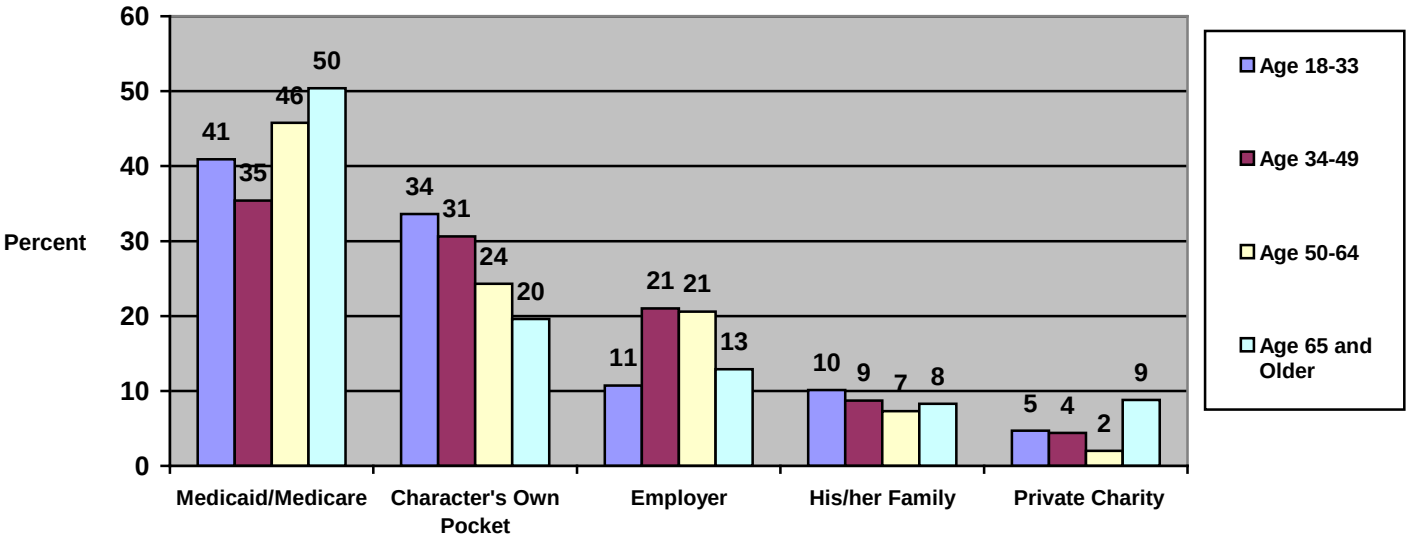
- Contrary to the data on physical health, older individuals were less likely than younger individuals to believe that the vignette character should have primary responsibility for his or her own mental health costs.

- Middle aged individuals (those aged 34-64) were more likely than younger and older individuals to believe the employer should take primary responsibility for payment of the vignette character's mental health costs. (See Figure 15, pg. 41).

- Younger respondents (aged 18-33) were most likely to believe that the character's family should take secondary responsibility for his or her mental health costs. Middle-aged respondents were more likely than younger and older respondents to believe that the character should take secondary responsibility for his or her own mental health costs.

- Similar to the data on physical health, African-Americans were less likely than white respondents to believe the vignette character should take primary responsibility for his or her mental health costs, and more likely to believe Medicaid or Medicare should take primary responsibility.

Figure 15.
Primary Responsibility for the Vignette Character's Mental Health Costs by Respondents' Age.



- White respondents were more likely than African-Americans to believe the character's family should take secondary responsibility for the character's mental health costs.

Responsibility for Physical Health

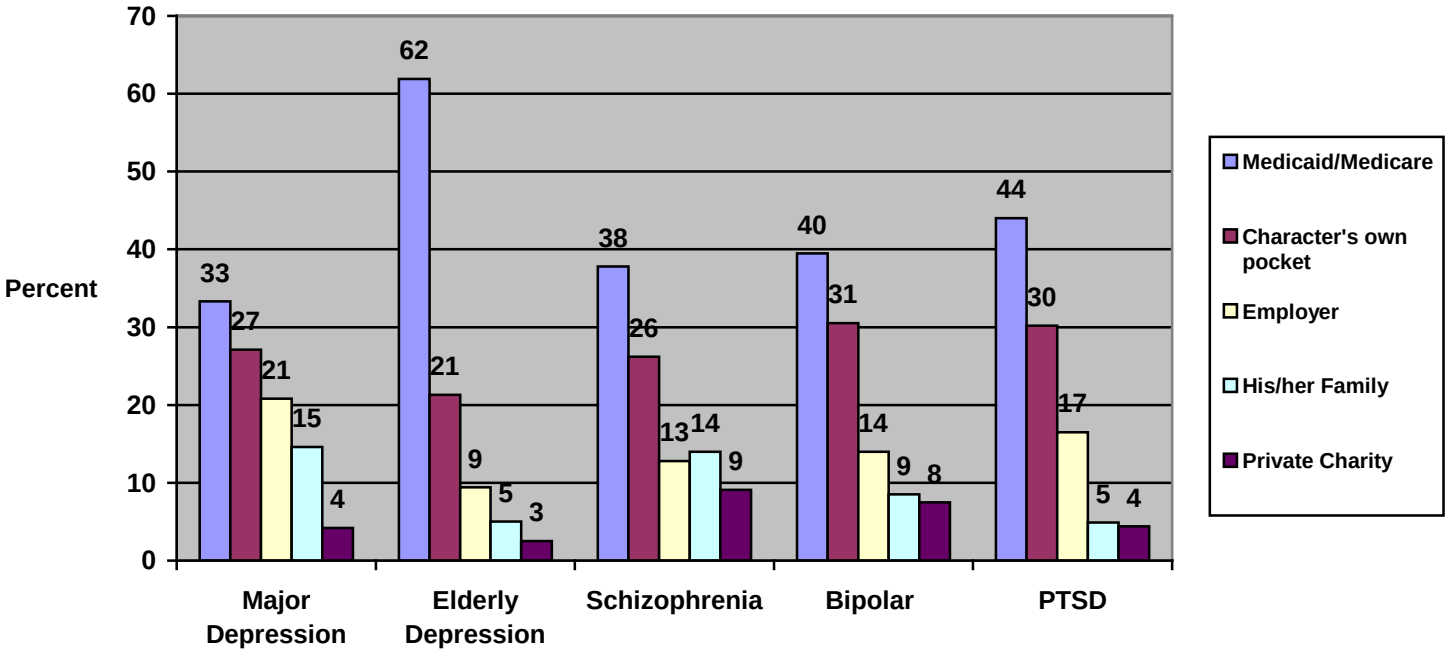
- Respondents were significantly more likely to believe that Medicaid or Medicare should take primary responsibility for the physical health costs of vignette characters with elderly depression, and less likely to believe that characters with elderly depression should be responsible for their own physical health costs.

- Respondents were more likely to believe that the families of characters with MDD or schizophrenia should take primary responsibility for the vignette character's physical health costs. See Figure 16, pg. 42 for more details.

- Older individuals were more likely than younger individuals to believe that the vignette character should take primary responsibility for his or her own physical health costs. They were also less likely than other age groups to believe that the vignette character's employer should take primary responsibility, and more likely to believe that Medicaid or Medicare should.

- African-Americans were significantly more likely than whites to believe that Medicaid or Medicare should take primary responsibility for the vignette character's physical health costs, and significantly less likely to believe that the vignette character should take primary responsibility for his or her health costs.

Figure 16.
Primary Responsibility for the Vignette Character's Physical Health Costs by Vignette



- Those with more education were least likely to believe that Medicaid or Medicare should take primary responsibility for the vignette characters physical health costs, and more likely to believe that the vignette character should take primary responsibility for his or her health costs.

Higher education does not translate into support for public physical health funding: more educated respondents were less likely to want Medicaid or Medicare to pay for physical health care problems of those with mental illness.

Summary: Treatment of Mental Illness

Consistent with data on mental health stigma, respondents were least likely to believe that schizophrenic individuals were able to make decisions regarding their own treatment, least likely to believe they would improve on their own, and most likely to believe they should be forced into treatment.

In contrast, respondents were more likely to feel that individuals with PTSD were able to make their own money and treatment decisions, more likely to believe they would improve on their own, and least likely to believe they should be forced into treatment. Considering most respondents did not view the vignette character with PTSD as suffering from "mental illness," the data regarding the schizophrenic individual (who was widely believed to be mentally ill) is most likely the best indicator of respondent attitudes towards individuals with mental illness in general.

Less educated individuals and males were more likely to believe that the character should be forced into treatment, especially if the character was schizophrenic or male. This may have to do with the perceived dangerousness of males with mental illness.

Finally, less educated individuals, males, and those in urban areas were less likely to believe the characters' condition would improve with treatment. Therefore, urban areas may serve as a good target for messages regarding the effectiveness of mental health treatment.

PERSONAL DEFINITION OF MENTAL ILLNESS

Respondents were asked the following open-ended question:

"Of course, everyone hears a great deal about physical illness and disease, but what about personals we call mentally ill? When you hear someone say that a person is "mentally ill," what does that mean to you?"

Respondents' answers to the open-ended question were given one of 17 codes. See Appendix B for an explanation of the codes and how coding decisions were made. Table 9, pg. 44 shows the percentage of responses that fell into each code. Each response could have up to 5 codes attached to it, resulting in some questions having more than one code. Therefore, two types of percentages are given. The first row gives the percentage of total responses that fell into any given code, and the second row lists the percentage of respondents whose responses were given that code.

Each code was also put into one of eight categories, based on whether it defined mental illness as biological, cognitive, emotional, behavioral, situational, medical, psychological, or other. The distribution of responses for each category is shown in Figure 17 on pg. 45.

The majority of Missourians view mental illness as a behavioral, emotional and/or cognitive phenomenon, respectively.

Results suggest that the majority of respondents (85%) view mental illness as a behavioral, emotional, and/or cognitive phenomenon, respectively. One fifth of responses (20%; 30.4% of respondents) suggested that mental illness was at least partially characterized by abnormal, psychotic, or dangerous behavior. Almost as many responses (19%; 29.9% of respondents) suggested that mood disorders and difficulties coping characterized mental illness. Approximately 16% of the total responses (24.1% of respondents) defined mental illness as either intellectual impairment, bad judgment, or an inability to function on a day to day basis. Overall, not being able to cope or function was considered the definition of mental illness by the largest percentage of respondents (18.7%), followed by being psychotic (14.8%).

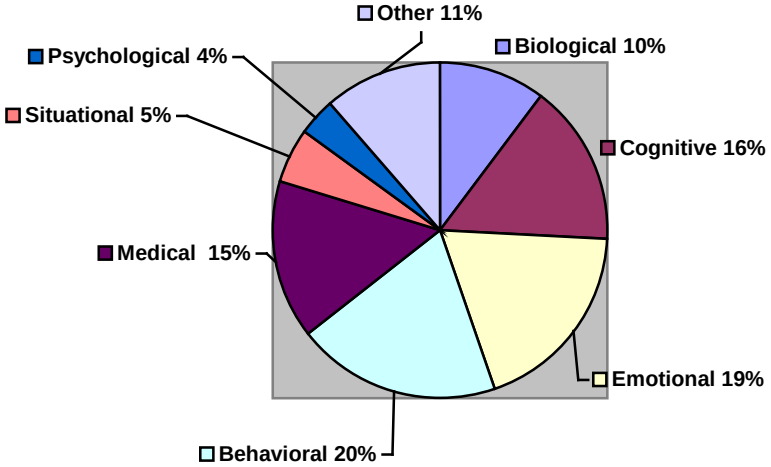
Interestingly, 8.3% of respondents felt that mental illness could not be easily defined. For example, one individual stated:

"I think of a huge range from somebody who is a little obsessive to people who are depressed and need treatment all the way up to people who are not able to be out on the streets. I see it as a huge range."

Table 9.
Respondents' Definitions of Mental Illness

Response Type	Frequency	Percent of Total Responses (n=1509)	Percent of Respondents (n=977)
Biological			
1. Brain Abnormality/Chemical Imbalance	136	8.9%	13.9%
2. Genetic	22	1.4%	2.3%
Cognitive			
3. Cognitively impaired/slow	132	8.7%	13.5%
4. Irrational/bad judgment	104	6.8%	10.6%
Emotional			
5. Mood Disorder/Anxiety	109	7.1%	11.2%
6. Difficulty Coping/Functioning	184	12.1%	18.7%
Behavioral			
7. Psychotic/Crazy	145	9.5%	14.8%
8. Dangerous to self/others	52	3.4%	5.3%
9. Abnormal Behavior	101	6.6%	10.3%
Situational			
10. Problems/Stressful Events	79	5.2%	8.1%
Medical			
11. Needs Treatment/Care	114	7.5%	11.7%
12. Illness/Disability	106	7.8%	12%
Psychological			
13. Psychological/Mental Problem	56	3.7%	5.7%
Other			
14. Mental Illness Cannot be Defined	81	5.4%	8.3%
15. Uncategorized	28	4%	5.8%
16. Don't Know/Refused	30	2.0%	3.1%
Totals	1509	100.0%	154.5%

Figure 17.
Respondents' Definitions of Mental Illness by Category



In an attempt to compare our results to previous studies using the same General Social Survey (GSS), we looked to an article by Phelan et. al. (2000). Phelan et. al. (2000) compared the 1996 results of the GSS, to GSS results from 1950. They found that the public definition of mental illness was much broader in 1996 than in 1950, in that respondents to the 1996 survey did not limit their perceptions of mental illness to psychotic disorders. They also found that the proportion of respondents that described a mentally ill person as violent increased 250% between 1950 and 1996. We wanted to see how our 2006 sample would compare to their results, so for comparison purposes, we coded our data into the following five categories they used for their study: Psychosis, Anxiety/Mood Problems, Social Deviance, Mental Deficiency/Cognitive Impairment, and Other Non-Psychotic. (See Appendix C for details).

The results are shown in Table 10, pg. 46. In some ways, our results were markedly different from those of both the 1950 and 1996 surveys. While some of this may be to coding differences, results are still striking. They suggest a trend towards more broad definitions of mental illness, as suggested by an increase in "Other" type responses, and a decrease in responses that pinpoint psychosis or depression as the defining features of mental illness.

Table 10.
Respondents' Definitions of Mental Illness Across Studies

	Phelan et. al. (2000) 1950 (N=337)	**Phelan et. al. (2000) 1996 (N=653)**	**Missouri Stigma Survey 2006 (N=977)**
Psychosis	40.7%	34.9%	14.6%
Anxiety/Depression	48.7%	34.3%	19.2%
Social Deviance	7.1%	15.5%	10.3%
Mental Deficiency/ Cognitive Impairment	6.5%	13.8%	15.5%
Other Non-Psychotic	7.1%	20.1%	45.6%

We also wanted to compare the perception of violence between our sample and the Phelan et. al. (2000) samples. The results are in Figure 18, pg. 47.

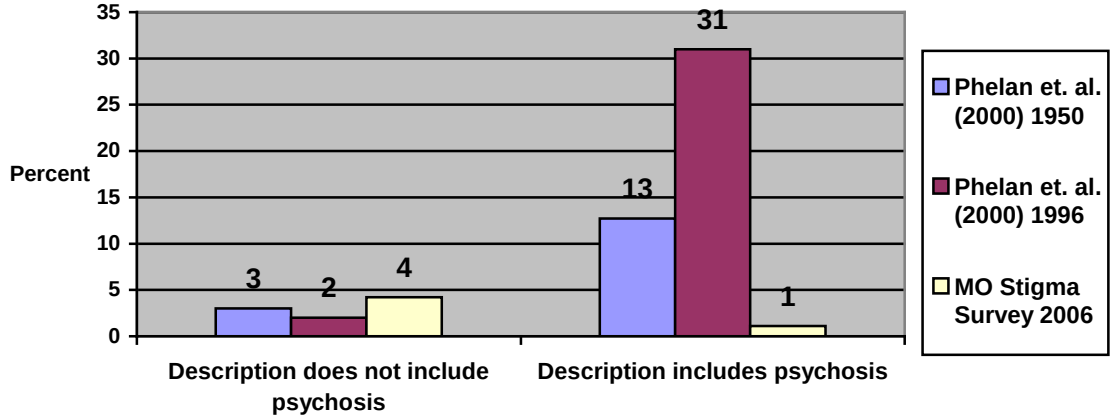
The perception that mentally people are dangerously psychotic individual has decreased dramatically since 1950.

The results suggest that, compared with the Phelan et. al. (2000) samples, the Missouri sample was much less likely to consider violent as part of the definition of mental illness. In particular, those who described mental illness in terms of psychosis were less likely than those in the Phelan et. al. (2000) sample to also include violence in their descriptions. Unlike the Phelan et. al. (2000) results, our results suggest that the mental illness stereotype of a dangerously psychotic individual has dramatically decreased since 1950.

However, that a small subsection of the population considers the mentally ill as likely to be violent has remained unchanged since 1950. Nonetheless, these results combined with those in Table 10 suggest that Missourian views regarding mental illness have broadened to include several types of mental difficulties. Indeed, that 8.3% of individuals refused to attempt to answer the question due to the fact they felt mental illness was too varied to be easily defined is telling. That, combined with the varied answers given by those who did answer the question, suggests a substantial broadening of views about mental illness.

Results suggest that people's perceptions of mental illness have broadened substantially over the past 50 years.

Figure 18.
Percent of Respondents whose Description of Mental Illness Includes Perceptions of Violence



Summary: Personal Definition of Mental Illness

Although a third of respondents defined mental illness as indicating abnormal, psychotic, or dangerous behavior, a closer look at the data suggests that very few respondents (less than 5%) actually spontaneously mention dangerous behavior when asked for a definition of mental illness.

- In fact, comparisons with other samples showed that our 2006 Missouri sample mentioned dangerousness much less than those from similar studies done in 1950 and 1996.
- The results also suggest that the stereotypical "dangerous and psychotic" view of mentally ill individuals is not as prevalent in our Missouri sample as other samples. Less than 2% of the sample described a dangerously psychotic individual when asked to define mental illness.

Furthermore, although psychoticism and depression were still prevalent definitions of the mentally ill by respondents, comparison with other data samples suggest that our Missouri sample of respondents have a substantially broader definition of mental illness than nationwide samples collected in 1950 and 1996.

- Not being able to cope or function was the most often mentioned definition of mental illness among respondents, although it should be noted that only 18.7% endorsed this definition, further illustrating that definitions varied widely.
- Another illustration of the trend towards broadening definitions of mental illness is the finding that 8.3% of Missourians sampled refused to answer the question, plainly stating that mental illness was too broad a category to be easily defined.

SOURCES OF INFORMATION REGARDING DEFINITIONS OF MENTAL ILLNESS

Respondents were also asked what helped them form their opinion about what mentally ill means, and were given several options from which to choose. They were instructed to check all that apply. Their options were as follows: 1) TV/Movies, 2) Books/Magazines, 3) Know someone with a mental illness, 4) Suffer from a mental illness myself, 5) Mental Illness campaigns, 6) Other types of media, 7) Other (specify), 8) Don't Know/Not sure, 9) Refuse to answer.

Almost half the sample report that knowing someone with mental illness helped inform their opinion regarding the definition of mental illness.

Figure 19 shows the results. Almost half the sample (45%) report that knowing someone with mental illness helped inform their opinion regarding the definition of mental illness. Similarly, almost half of the respondents listed that "other" sources influenced their opinion. The most commonly stated "other" sources are listed in Table 11 pg. 49. A large proportion of respondents who chose the "other" category as a source of information about mental illness felt that the nature of their work helped inform them about mental illness. The nature of these respondents' occupations varied widely, from mental health worker to nurse to business owner. A number of also respondents listed "life experience" as a common means of information about mental illness (22.8%).

Figure 19.
Sources of Information that Shaped Respondents' Definition Regarding Mental Illness

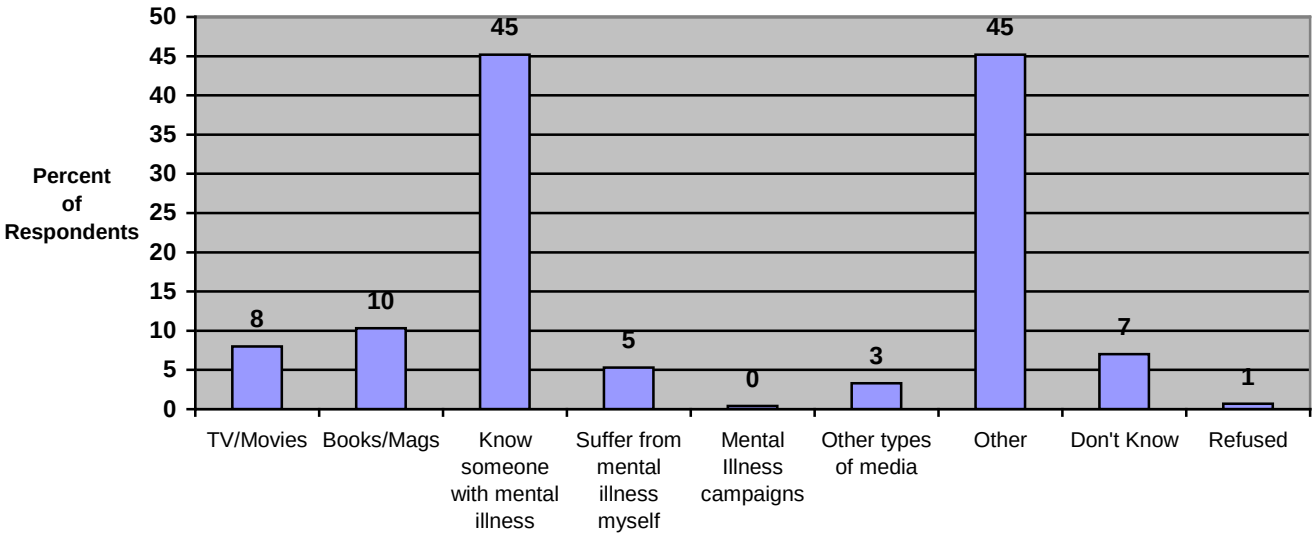


Table 11.
Other Sources of Information Affecting Respondents' Opinions About Mental Illness

	Frequency	Percent of Respondents	Percent of Total Responses
Work experience	113	24.7%	26.4%
Own opinion/feelings	68	14.9%	15.9%
Education	69	15.1%	16.1%
Personal experience	104	22.8%	24.3%
General knowledge/common sense	14	3.1%	3.3%
Observation of people/mentally ill	44	9.6%	10.3%
Other people	25	5.5%	5.8%
How raised	15	3.3%	3.5%
News stories	5	1.1%	1.2%
Total	457	100%	106.8%*

Note: Value is greater than 100% because respondents could give more than one answer to each question.

After respondents were asked what helped them form their opinion, they were asked which of the following had the *most* influence on the opinion: 1) TV/Movies, 2) Books/Magazines, 3) Personal Experience, 4) Mental Illness campaigns, 5) Other types of media, 6) Other (specify), 7) Don't Know/Not sure, 8) Refuse to answer.

The results are shown in Figure 20, pg. 50. Knowing someone with mental illness was seen as the most influential source of information for more than a third of respondents (35%). Interestingly, although TV and movies were seen as a major source of information by less than 10% of respondents (see Figure 19, pg. 47), almost 20% felt they were the biggest influence on their opinions about mental illness.

Once again, a number of respondents chose the "other" category. As Table 12, pg. 50b shows, the most influential source of information for these respondents was work experience (20% of respondents mentioned this). Education (16%) and observation (16%) were also cited as the most influential sources of information by some respondents.

Figure 20.
Information that Most Influenced Respondents' Opinions about Mental Illness

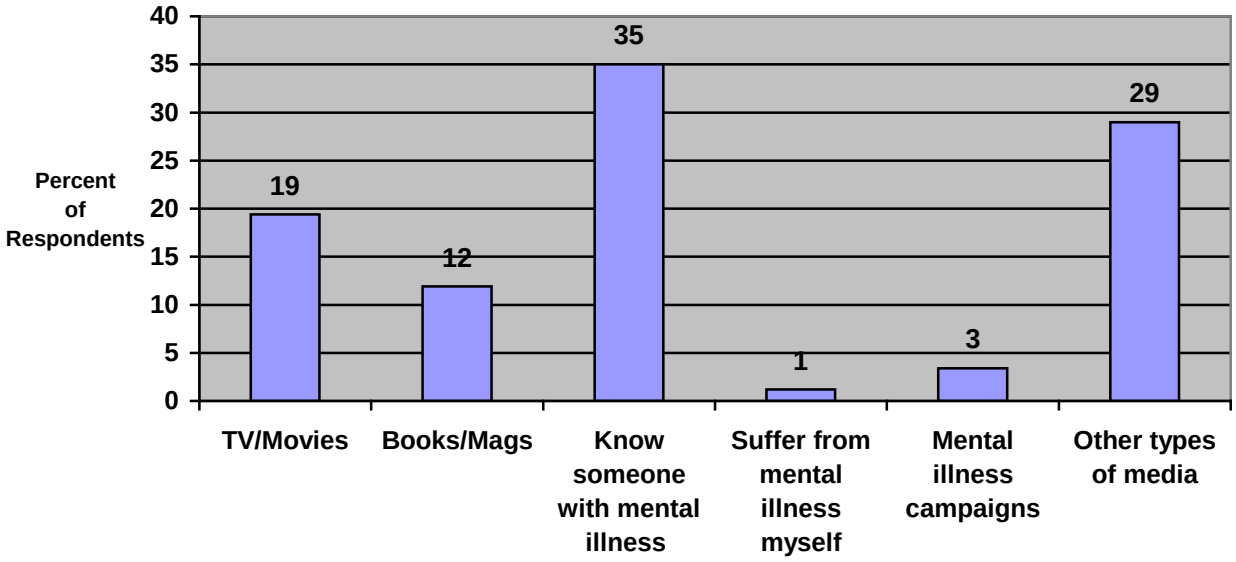


Table 12.
Other Sources of Information that Most Influenced Respondents' Opinions About Mental Illness

	Frequency	Percent of Respondents	Percent of Total Responses
Work experience	10	20.0%	20.8%
Own opinion/feelings	7	14.0%	14.6%
Education	8	16.0%	16.7%
Personal experience	6	12.0%	12.5%
General knowledge/common sense	2	4.0%	4.2%
Observation of people/mentally ill	8	16.0%	16.7%
Other people	5	10.0%	10.4%
How raised	3	6.0%	6.3%
News stories	1	2.0%	2.1%
Total	50	100.0%	104.2%

Note: Value is greater than 100% because respondents could give more than one answer to each question.

Impact of Most Influential Sources on Stigma and Mental Health Knowledge.

We were interested in whether respondents' most influential source of information regarding mental illness would have an impact on their level of knowledge about mental illness and level of stigma. Results suggested that source of information had a substantial impact on both.

Causes of Mental Illness

- The highest percentage (approximately a third) of those who listed TV and movies or books as magazines as their most influential sources of information about mental illness believed mental illness was a result of bad character.
  - None of those who stated that suffering from mental illness themselves was their most influential source of information about mental illness believed mental illness was the result of bad character.
- Those who stated that suffering from mental illness themselves was their most influential source of information about mental illness believed stressful circumstances and chemical imbalance were the most likely cause of mental illness.
  - Chemical imbalance was also deemed likely by those who listed books or magazines or "other" as their most likely source of information.
  - Stressful Circumstances was prevalent among everyone, although those who have suffered from mental illness and those who consider mental illness campaigns as their most influential source of information believed it most strongly.
- Genetics was a likely answer among those who list books, magazines or knowing someone with mental illness as their primary source of information about mental illness.
- Aging and a higher power were considered as likely causes of mental illness by a majority of those who listed mental illness campaigns as their primary source of information about mental illness (although sample sizes were low).

Mental Health Stigma

- In general, those who listed TV and Movies as their primary source of information about mental illness were less willing to interact with a mentally ill individual.

Those who listed TV and movies as their primary source of information about mental illness were less willing to interact with a mentally ill individual.

- Those who list books and magazines as their primary source were most likely to be willing to socialize and make friends with a mentally ill individual.
  - However, they were much less likely to work with a mentally ill individual, allow a mentally ill individual to marry into his or her family, or allow a group home in their neighborhood for mentally ill individuals.
  - They were also one of the groups most likely to believe a mentally ill individual will be violent towards others.

- Those who list mental illness campaigns as their primary source of information were most likely to be willing to work with a mentally ill individual or allow a mentally ill individual to marry into his or her family.
- Interestingly, stigma was relatively high among people who have list suffering from their own mental illness as their most influential source of information, although the sample size is low (n=13).
- Levels of stigma were lowest among those who cite mental illness campaigns and knowing someone with mental illness as their most influential sources of information about mental illness.
- Those who stated "other" as their most influential source were most likely to believe mentally ill individuals are likely to be violent towards themselves.
    - This may be partially due to the fact that many of the individuals who chose "other" cited work experience as their most influential source of information. Therefore, they may see more violent mentally ill individuals than the average person, thus skewing their perception of those with mental illness.

Summary: Sources of Information Regarding Definitions of Mental Illness

- Missouri respondents felt that the largest contributor to their own knowledge of mental illness was knowing someone with mental illness.
    - Individuals who listed knowing a mentally ill individual as their most influential source of information about mental illness were less likely to stigmatize and were more knowledgeable about the causes of mental illness. This is consistent with our previous findings, which suggest that those with personal experience with mental illness are indeed more educated about mental illness, and less likely to stigmatize.

Individuals who listed knowing a mentally ill individual as their most influential source of information about mental illness were less likely to stigmatize and were more knowledgeable about the causes of mental illness

    - Respondents who chose mental illness campaigns as their most influential source of information about mental illness were less likely to stigmatize, although they seemed no more educated about mental illness than other groups.
        - This suggests that previous mental illness campaigns were likely effective at reducing stigma, although they were probably less effective at (or less likely to focus on) improving knowledge about mental illness.
        - This further illustrates that mental illness stigma and mental illness knowledge, while correlated, are not one in the same.

- After knowing someone with mental illness, TV and movies were considered the next most influential source of information regarding mental illness by respondents.
    - Unfortunately, those who listed TV and movies as their most influential source of information were less knowledgeable about mental illness and were most likely to stigmatize.

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APPENDIX A
Mental Health Stigma Telephone Survey
(Adapted from the Mental Health Module of the General Social Survey)

Field Size	Columns	Description of Field	Comments and Values
4	15-18	(respnum) Respondent number	Unique Identifier given to each record by WinCati the first time the record is attempted.
Columns are intentionally left blank.			
3	27-29	(AAPOR)	110=completed interview
8	30-37	(IDATE)	Date of interview (MMDDYYYY)
Columns 38-39 are intentionally left blank.			
2	40-41	Number of Attempts (NATTMPTS)	
Columns 42-56 are intentionally left blank.			
1	57	Correct telephone number? (CTELENUM)	1 = Yes 2 = No
1	58	Cellular Telephone (CELLFON)	1 = No, not a cellular telephone 2 =Yes
1	59	Private Residence? (PVTRESID)	1 = Yes 2 = No
2	60-61	(NUMADULT)	01-18=Number of adults in the household. Put on all complete and incomplete records for which these data are available.
2	62-63	(Men)	00-18=Number of adult men in the household. Put on all complete and incomplete records for which these data are available.
2	64-65	(Women)	00-18=Number of adult women in the household. Put on all complete and incomplete records for which these data are available.
Columns 66-99 are intentionally left blank.			
2	100-101	(vigntt) Vignette randomly chosen	1 – Vignette A Female 2 – Vignette B Female 3 – Vignette C Female 4 – Vignette D Female 5 – Vignette E Female 6 – Vignette A Male 7 – Vignette B Male 8 – Vignette C Male 9 – Vignette D Male 10 – Vignette E Male

Field Size	Columns	Description of Field	Comments and Values
In your opinion, how likely is it that NAME's situation might be caused by:			
1	102	1. (C01Q01) His/her own bad character?	**Please read:** 1 Very Likely 2 Somewhat Likely 3 Somewhat Unlikely 4 Very Unlikely **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	103	2. (C01Q02) A chemical imbalance in the brain?	**Please read:** 1 Very Likely 2 Somewhat Likely 3 Somewhat Unlikely 4 Very Unlikely **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	104	3. (C01Q03) The way (s/he) was raised?	**Please read:** 1 Very Likely 2 Somewhat Likely 3 Somewhat Unlikely 4 Very Unlikely **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	105	4. (C01Q04) Stressful circumstances in his/her life?	**Please read:** 1 Very Likely 2 Somewhat Likely 3 Somewhat Unlikely 4 Very Unlikely **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	106	5. (C01Q05) A genetic or inherited problem?	**Please read:** 1 Very Likely 2 Somewhat Likely 3 Somewhat Unlikely 4 Very Unlikely **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	107	6. (C01Q06) The will of a higher power?	**Please read:** 1 Very Likely 2 Somewhat Likely 3 Somewhat Unlikely 4 Very Unlikely **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	108	7. (C01Q07) Aging?	**Please read:** 1 Very Likely 2 Somewhat Likely 3 Somewhat Unlikely 4 Very Unlikely **Do not read:** 7 Don't Know/Not Sure 9 Refused

Field Size	Columns	Description of Field	Comments and Values
In your opinion, how likely is it that NAME is experiencing:			
1	109	8. (C01Q08) Part of the normal ups and downs of life?	**Please read:** 1 Very Likely 2 Somewhat Likely 3 Somewhat Unlikely 4 Very Unlikely **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	110	9. (C01Q09) A nervous breakdown?	**Please read:** 1 Very Likely 2 Somewhat Likely 3 Somewhat Unlikely 4 Very Unlikely **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	111	10. (C01Q10) A mental illness?	**Please read:** 1 Very Likely 2 Somewhat Likely 3 Somewhat Unlikely 4 Very Unlikely **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	112	11. (C01Q11) A physical illness?	**Please read:** 1 Very Likely 2 Somewhat Likely 3 Somewhat Unlikely 4 Very Unlikely **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	113	IF VIGNETTE = A, READ: 12. (C01Q12) Major depressive disorder?	**Please read:** 1 Very Likely 2 Somewhat Likely 3 Somewhat Unlikely 4 Very Unlikely **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	114	IF VIGNETTE = B, READ: 13. (C01Q13) Elderly depression?	**Please read:** 1 Very Likely 2 Somewhat Likely 3 Somewhat Unlikely 4 Very Unlikely **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	115	IF VIGNETTE = C, READ: 14. (C01Q14) Schizophrenia?	**Please read:** 1 Very Likely 2 Somewhat Likely 3 Somewhat Unlikely 4 Very Unlikely **Do not read:** 7 Don't Know/Not Sure 9 Refused

Field Size	Columns	Description of Field	Comments and Values
1	116	IF VIGNETTE = D, READ: 15. (C01Q15) Bipolar Disorder?	**Please read:** 1 Very Likely 2 Somewhat Likely 3 Somewhat Unlikely 4 Very Unlikely **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	117	IF VIGNETTE = E, READ: 16. (C01Q16) Post Traumatic Stress Disorder?	**Please read:** 1 Very Likely 2 Somewhat Likely 3 Somewhat Unlikely 4 Very Unlikely **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	118	17. (C01Q17) In your opinion, how able is NAME to make his/her own decisions about the treatment s/he should receive?	**Please read:** 1 Very Able 2 Somewhat Able 3 Somewhat Unable 4 Very Unable **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	119	18. (C01Q18) In your opinion, how able is NAME to make his/her own decisions about managing his/her own money?	**Please read:** 1 Very Able 2 Somewhat Able 3 Somewhat Unable 4 Very Unable **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	120	19. (C01Q19) In your opinion, how likely is it that NAME's situation will improve on it's own?	**Please read:** 1 Very Likely 2 Somewhat Likely 3 Somewhat Unlikely 4 Very Unlikely **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	121	20. (C01Q02) In your opinion, how likely is it that NAME's situation will improve with treatment?	**Please read:** 1 Very Likely 2 Somewhat Likely 3 Somewhat Unlikely 4 Very Unlikely **Do not read:** 7 Don't Know/Not Sure 9 Refused
How willing would you be…			
1	122	21. (C01Q21) to move next door to NAME?	**Please read:** 1 Definitely Willing 2 Probably Willing 3 Probably Unwilling 4 Definitely Unwilling **Do not read:** 7 Don't Know/Not Sure 9 Refused

Field Size	Columns	Description of Field	Comments and Values
1	123	22. (C01Q22) to spend an evening socializing with NAME?	**Please read:** 1 Definitely Willing 2 Probably Willing 3 Probably Unwilling 4 Definitely Unwilling **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	124	23. (C01Q23) to make friends with NAME?	**Please read:** 1 Definitely Willing 2 Probably Willing 3 Probably Unwilling 4 Definitely Unwilling **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	125	24. (C01Q24) to have NAME start working closely with you on a job?	**Please read:** 1 Definitely Willing 2 Probably Willing 3 Probably Unwilling 4 Definitely Unwilling **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	126	25. (C01Q25) to have a group home for people like NAME opened in your neighborhood?	**Please read:** 1 Definitely Willing 2 Probably Willing 3 Probably Unwilling 4 Definitely Unwilling **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	127	26. (C01Q26) to have NAME marry into your family?	**Please read:** 1 Definitely Willing 2 Probably Willing 3 Probably Unwilling 4 Definitely Unwilling **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	128	27. (C01Q27) In your opinion, how likely is it that NAME would do something violent toward other people?	**Please read:** 1 Very Likely 2 Somewhat Likely 3 Somewhat Unlikely 4 Very Unlikely **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	129	28. (C01Q28) In your opinion, how likely is it that NAME would do something violent toward him/herself?	**Please read:** 1 Very Likely 2 Somewhat Likely 3 Somewhat Unlikely 4 Very Unlikely **Do not read:** 7 Don't Know/Not Sure 9 Refused

Field Size	Columns	Description of Field	Comments and Values
Some cities and states have laws that force people with problems like NAME into treatment. Do you think that people like NAME should be forced by law to…			
1	130	29. (C01Q29) Get treatment at a clinic or from a doctor?	1 Yes 2 No **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	131	30. (C01Q30) Take a prescription medication to control his/her behavior?	1 Yes 2 No **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	132	31. (C01Q31) Be admitted to a hospital for treatment?	1 Yes 2 No **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	133	32. (C01Q32) Be admitted to a hospital for treatment if s/he is dangerous to him/herself?	1 Yes 2 No **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	134	33. (C01Q33) Be admitted to a hospital for treatment if s/he is dangerous to other's?	1 Yes 2 No **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	135	34. (C01Q34) In your opinion, who should be most responsible for paying the cost of NAME's physical medical care and treatment?	**Please read:** 1 NAME's own pocket 2 His/her family 3 Employer 4 Medicaid/Medicare 5 Private Charity **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	136	35. (C01Q35) Who should be next most responsible?	**Please read:** 1 NAME's own pocket 2 His/her family 3 Employer 4 Medicaid/Medicare 5 Private Charity **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	137	36. (C01Q36) In your opinion, who should be most responsible for paying the cost of NAME's mental health care and treatment?	**Please read:** 1 NAME's own pocket 2 His/her family 3 Employer 4 Medicaid/Medicare 5 Private Charity **Do not read:** 7 Don't Know/Not Sure 9 Refused

Field Size	Columns	Description of Field	Comments and Values
1	138	37. (C01Q37) Who should be next most responsible?	**Please read:** 1 NAME's own pocket 2 His/her family 3 Employer 4 Medicaid/Medicare 5 Private Charity **Do not read:** 7 Don't Know/Not Sure 9 Refused
Question 38 is asked at this point. The location of this question is at the end of the data layout.			
18	139-156	39. (C01Q39) What helped you to form this opinion?	**Silent Code (CHECK ALL THAT APPLY):** 01 TV/Movies 02 Books/Magazines 03 Know someone with a mental illness 04 Suffer from a mental illness myself 05 Mental illness campaigns 06 Other Types of Media 07 Other (Specify) **Do not read:** 77 Don't Know/Not Sure 99 Refused
Ask Question 40 only if given more than one answer to Question 39.			
1	157	40. (C01Q40) Which one had the most influence on this opinion?	**Silent Code:** 1 TV/Movies 2 Books/Magazines 3 Personal Experience 4 Mental illness campaigns 5 Other Types of Media 6 Other (Specify) **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	158	41. (C01Q41) Have you ever known anyone who has a serious mental illness?	1 Yes 2 No **Do not read:** 7 Don't Know/Not Sure 9 Refused
If Question 41 > 1, skip to Question 44			
2	159-160	42. (C01Q42) What was your relationship to this person?	**Please read:** 01 Respondent 02 Immediate Family Member 03 Other Relatives 04 Close Friend 05 Coworker 06 Acquaintance 07 Other (Specify) **Do not read:** 77 Don't Know/Not Sure 99 Refused
1	161	43. (C01Q43) Were any of these individuals experiencing problems starting at the age of 65 or older?	1 Yes 2 No **Do not read:** 7 Don't Know/Not Sure 9 Refused

Field Size	Columns	Description of Field	Comments and Values
1	162	44. (C01Q44) Have you ever lived near anyone who had a serious mental illness?	1 Yes 2 No **Do not read:** 7 Don't Know/Not Sure 9 Refused
If Question 44 > 1, skip to Question 46			
2	163-164	45. (C01Q45) What was your relationship to this person?	**Please read:** 01 Immediate Family Member 02 Other Relatives 03 Close Friends 04 Coworker 05 Acquaintances 06 Community member 07 Other (Specify) **Do not read:** 77 Don't Know/Not Sure 99 Refused
1	165	46. (C01Q46) Have you ever known anyone (other than persons mentioned earlier) who was seeing a psychologist, mental health professional, therapist, social worker, or other type of counselor?	1 Yes 2 No **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	166	47. (C01Q47) Did you ever feel you had a mental health problem?	1 Yes 2 No **Do not read:** 7 Don't Know/Not Sure 9 Refused
If Question 47 > 1, skip to Question 64			
1	167	48. (C01Q48) Have you ever sought help for the mental health problem?	1 Yes 2 No **Do not read:** 7 Don't Know/Not Sure 9 Refused
If Question 48 > 1, skip to Question 51			
2	168-169	49. (C01Q49) Who did you seek help from?	**Please read:** 01 Psychologist 02 Psychiatrist/Psychoanalyst 03 General Practitioner/Family Doctor 04 Social Worker/Therapist 05 Minister/Clergy 06 Friend/Family 07 Other (Specify) **Do not read:** 77 Don't Know/Not Sure 99 Refused
1	170	50. (C01Q50) Did the treatment help?	1 Yes 2 No **Do not read:** 7 Don't Know/Not Sure 9 Refused

Field Size	Columns	Description of Field	Comments and Values
1	171	51. (C01Q51) Was there ever a time in the past 12 months when you felt that you might need to get help for a mental health problem, but you didn't get help?	1 Yes 2 No **Do not read:** 7 Don't Know/Not Sure 9 Refused
If Question 51 > 1, skip to Question 64			
I'm going to read you a list of reasons people have for not seeking help or not getting as much help as they want even when they think they might need it. As I read each statement, please let me know whether this was a reason that you didn't get help for your mental health problem in the past 12 months.			
1	172	52. (C01Q52) My health insurance would not cover this kind of treatment.	1 Yes 2 No 3 I do not have health insurance **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	173	53. (C01Q53) I think I can handle these kinds of problems on my own.	1 Yes 2 No **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	174	54. (C01Q54) I thought the problem would get better by itself.	1 Yes 2 No **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	175	55. (C01Q55) It was too expensive.	1 Yes 2 No **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	176	56. (C01Q56) I was unsure about where to go.	1 Yes 2 No **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	177	57. (C01Q57) Help probably would not do any good.	1 Yes 2 No **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	178	58. (C01Q58) I was concerned about what others might think.	1 Yes 2 No **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	179	59. (C01Q59) I didn't want others to know.	1 Yes 2 No **Do not read:** 7 Don't Know/Not Sure 9 Refused

Field Size	Columns	Description of Field	Comments and Values
1	180	60. (C01Q60) It would take too much time.	1 Yes 2 No **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	181	61. (C01Q61) I went in the past but it did not help.	1 Yes 2 No **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	182	62. (C01Q62) I didn't have the transportation.	1 Yes 2 No **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	183	63. (C01Q63) Other (specify)	1 Yes 2 No **Do not read:** 7 Don't Know/Not Sure 9 Refused
Now, I have some general questions about you.			
2	184-185	64. (C01Q64) What is your age?	_____Age in years 7 Don't Know/Not Sure 9 Refused
1	186	65. (C01Q65) Indicate sex of respondent (Ask only if necessary)	1 Male 2 Female 3 Other 9 Refused
1	187	66. (C01Q66) Are you of Hispanic or Latino cultural/ethnic background?	1 Yes 2 No **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	188	67. (C01Q67) And which racial/ethnic group best describes you?	**Please read:** 1 American Indian or Alaska Native 2 Asian or Pacific Islander 3 Black or African American 4 White 5 Other (specify) **Do not read:** 7 Don't Know/Not Sure 9 Refused

Field Size	Columns	Description of Field	Comments and Values
2	189-190	68. (C01Q68) What is the highest level of education that you have completed?	01 8th grade or less 02 Some high school 03 High school graduate 04 GED or high school equivalent 05 Some college 06 Bachelor's Degree (BA, BS, BSN, BSW, BFA, B.Ed.) 07 Master's Degree (MA, MS, MBA, MSN, MSW, M.Ed.) 08 Professional/Doctoral Degree (J.D., M.D., Ph.D., Ed.D.) **Do not read:** 77 Don't Know/Not Sure 99 Refused
1	191	69. (C01Q69) Are you currently—married, widowed, divorced, separated, or have you never been married?	1 Married 2 Widowed 3 Divorced 4 Separated 5 Never been married **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	192	70. (C01Q70) Do you consider where you live to be urban, suburban, or rural?	1 Urban 2 Suburban 3 Rural **Do not read:** 7 Don't Know/Not Sure 9 Refused
3	193-195	71. (C01Q71) In what county do you currently live?	_____Enter County FIPS code 777 Don't Know/Not Sure 999 Refused
5	196-200	72. (C01Q72) What is the zip code where you live?	_____Enter 5-digit zip code 77777 Don't Know/Not Sure 99999 Refused
1	201	73. (C01Q73) Do you have more than one telephone number in your household? Do not include cell phones or number that are only being used by a computer or fax machine.	1 Yes 2 No **Do not read:** 7 Don't Know/Not Sure 9 Refused
If Question 73 > 1, skip to Question 75.			
1	202	74. (C01Q74) How many of these phone numbers are residential numbers?	1 One 2 Two 3 Three 4 Four 5 Five 6 Six or more **Do not read:** 7 Don't Know/Not Sure 9 Refused
1	203	75. (C01Q75) During the past 12 months, has your household been without telephone service for 1 week or more? Do not include interruptions of phone service due to weather or natural disasters.	1 Yes 2 No **Do not read:** 7 Don't Know/Not Sure 9 Refused

Field Size	Columns	Description of Field	Comments and Values
1	204	76. (C01Q76) In which of these groups did your total family income, from all sources, fall last year before taxes, that is?	1 Less than $20,000 2 $20,000 – $34,999 3 $35,000 – $49,999 4 $50,000 – $74,999 5 $75,000 - $99,999 6 $100,000 or more **Do not read:** 7 Don't Know/Not Sure 9 Refused
350	205-554	38. (C01Q38) LET'S TURN AWAY FROM NAME, NOW. Of course, everybody hears a good deal about physical illness and disease, but what about persons we call mentally ill? When you hear someone say that a person is "mentally ill," what does that mean to you?	
150	555-704	40A. (C01Q40A) Other (specify) response to Question 40	
50	705-754	42A. (C01Q42A) Other (specify) response to Question 42	
100	755-854	45A. (C01Q45A) Other (specify) response to Question 45	
100	855-954	49A. (C01Q49A) Other (specify) response to Question 49	
150	955-1104	63A. (C01Q63A) Other (specify) response to Question 63	
50	1105-1154	67A. (C01Q67A) Other (specify) response to Question 67	
60	1155-1214	39A. (C01Q39A) Other (specify) response to Question 39	
1	1250	(Closing) End of file marker	

APPENDIX B

To compare our results with the Phelan et. al. (2000) study, we coded our data into the same five categories they used for their study:

- **Psychosis.** In line with the procedures in Phelan et. al. (2000), psychosis was coded when the respondents mentioned symptoms that suggested a break with reality or craziness. Since the Phelen et. al. (2000) definition of psychosis fit nicely with our category of "Psychotic/Crazy" (See #8 in Appendix), we treated the two as synonymous.
- **Anxiety/Mood Problems.** The Phelan et. al. (2000) definition of anxiety and mood problems included any symptoms characteristic of a diagnosis of mood disorder, including anxiety, depressive symptoms, extreme or labile emotions, inability to cope or function, and social withdrawal. Our existing code of "Mood Disorder/Emotional Disturbance" was very similar, with the exclusion of coping. Therefore, we added our code "Difficulty Coping/Functioning" to our "Mood Disorder/Emotional Disturbance" codes to approximate the Phelan et. al. (2000) category.
- **Social Deviance.** Phelan et. al. (2000) defined social deviance as a reference to abnormal or strange behavior, and difficulty fitting in with society. This approximated our category of "Abnormal Behavior" (See # in Appendix) so we treated the two as synonymous.
- **Mental Deficiency/Cognitive Impairment.** Phelen et. a. (2000) defined mental deficiency as any problems thinking or reasoning. For this category, we combined two of our codes: "Cognitively Impaired/Slow" and "Irrational/Bad Judgment." If a response fit with either of these two codes, it was placed in this category.
- **Other Non-Psychotic.** Phelan et. al. (2000) placed anything into this category which described a symptom that did not fit into the other four categories. They cite placing references to other disorders, chemical imbalance, mental problems, and other uncategorizable responses in this category. Therefore, for our purposes, we combined all codes not previously used, with the exception of "Don't Know/Refused" and "Mental Illness Cannot Be Defined."

APPENDIX C

Personal Definition of Mental Illness: Response Categories

1. Brain Abnormality/Chemical Imbalance

Includes any response that suggests the brain is not functioning correctly. Includes responses that suggest mental illness results from a chemical imbalance in the brain.

Examples:

- "There is some sort of malfunction with their brain"
- "It means that there is something wrong with that person's brain."
- "There is an imbalance in their brain."
- "They have some kind of chemical imbalance."

2. Genetic

Includes any response that suggests mental illness has a genetic basis.

Examples:

- "Born with genetic disease."
- "It's a genetic thing where they are not like everyone else."
- "Born that way."
- "Born with a problem."

3. Cognitively Impaired/Slow

Some respondents felt that mentally ill individuals were cognitively deficient, impaired, or slow. Any response that suggested that mentally ill individuals have impaired intellect falls into this category.

Examples:

- Mentally challenged…below average I.Q.
- It means they can't connect the dots they have some kind of thought impairment
- They are limited in some mental skills and abilities to perform on par with other people
- Retarded or slow, incapable of thinking properly.

4. Irrational/Bad Judgment

Responses were coded as "Irrational/Bad judgment" if they suggest mental illness is defined by an individual who cannot make good decisions, or who is irrational. It includes responses that suggest mentally ill individuals are not able to make decisions on their own or are "unbalanced" in some way (which implies bad judgment).

Examples:

- "Someone who cannot make decisions for themselves. Can't make judgments for themselves. Bottom line."
- "They make irrational decisions and behaviors."
- "Unable to make sound decisions on a consistent basis."
- "Someone that can't make a rational decision."

5. Mood Disorder/Anxiety

Includes any response that defines mental illness as an emotional disturbance, or that define individuals with mental illness by their emotional state, such as "moody," "anxious" or "angry." Included are responses that define mental illness as depression or sadness.

- "I would think of them as someone who struggle with their emotions and their ability to deal with their emotions."
- "They're disturbed."
- "Mood swings."
- "You can tell when a person is mentally ill. Everything you say they take offense."
- "They're depressed."
- "Someone that is always depressed."
- "Depressed."

6. Difficulty Coping/Functioning

Includes any response that defines mental illness as an inability to function normally within society, cope with everyday life, or to take care of themselves.

Examples:

- "They're just not able to cope with anything."
- "They just can't function in a day to day life."
- "Person not capable of not managing their own life, such as household duties, finances and everyday living."
- "Not quite capable of taking care of themselves."

7. Psychotic/Crazy

Some respondents defined mental illness as someone who is psychotic. Included in this category are respondents who defined mental illness as someone who is schizophrenic. Also included are responses that suggest a mentally ill individual has lost touch with reality, is psychotic, "crazy," unpredictable, or cannot control their actions.

Examples:

- "I think of illness as something chronic like psychosis or schizophrenia."
- "Someone who is losing or has lost touch with reality."
- "Someone suffering, can't tell reality from fantasy."
- "Someone that is insane."
- "Someone who doesn't have full control of their feelings or their actions."

8. Dangerous to Self/Others

Includes any response that suggests mental illness is defined by violence, aggression, or danger to the self or others.

Examples:

- "They are a danger to themselves or others because they have mental issues."
- "Someone who is a danger to themselves and others."
- "They are subject to hurt themselves or someone else."
- "In most cases the person is dangerous."

9. Abnormal Behavior

Any response that suggests that mental illness is defined as an abnormal individual falls into this category, as well as any description of difficulty fitting into normal society or description of abnormal behavior.

Examples:

- "That they're not the norm, the average, they're just different."
- "If someone exhibits extreme behavior outside the norm."
- "They don't process things in the world the same as other people do. They don't perceive things the way others do."
- "Not really like other people."

10. Problems/Stressful Events

Includes responses that define mental illness as an individual who was an unspecified "problem" or "issue." It also includes responses that define mental illness as a result of stressful events.

Examples:

- "Have some issues, what they are varies."
- "A situation they can't handle."
- It means that they have an overwhelming situation. They have a problem and you need to do research on the problem.
- "Could be financial, family, etc problems."
- "Have something, issue to deal with."

11. Needs Treatment/Care

Any responses that defined mental illness as an individual who needs help or treatment was coded in this category.

Examples:

- "That person needs help. Might have to be hospitalized."
- "Means they need a lot of therapy, possibly medication."
- "Serious, should be confined. If there is a chance of improving then maybe could be on his own. Should not be left on the street, too dangerous for them. They should get assistance from the state, county and government. Should get assistance from charities. Family should pay first."
- "It means they need to get help. Whatever it takes to get help from Medicaid or disability."

12. Illness

Any response that defines mental illness as a medical condition, ailment, disability or illness, physical or otherwise.

Examples:

- "Have an illness just like physical."
- "A mentally ill person has a medical problem."
- "They have a sickness."
- "There is a physical problem with them."
- "They are handicapped."

13. Mental Problem/Malfunction

Includes any response that defined mental illness as a malfunction in mental processes. Also includes responses that indicate mental illness is a mental or psychological problem or issue.

Examples:

- "They don't have physical problems that you can see, they have head problems."
- "Psychological problems."
- "That they have mental problems."
- "They got something wrong with their mind."
- "They have some mental issues."

14. Mental Illness Cannot be Defined

A number of respondents felt that no universal definition of mental illness exists, or that an easy definition was difficult to come by. They generally cited the fact that mental illness was varied and difficult to define narrowly.

Examples:

- This question is too vague to answer because such wide area could be considered mental illness.
- Mental illness should be done case by case. Should not be stereotyped, there are different degrees of mental illness.
- I think of a huge range from somebody who is a little obsessive to people who are depressed and need treatment all the way up to people who are not able to be out on the streets. I see it as a huge range.
- There are so many spectrums in a rainbow. There is a wide range of mental health illnesses.

15. Uncategorized

Any response that does not fall into any particular category was placed in this category.

Examples:

- "Does not necessarily mean a bad thing. More of us probably have a mental illness than don't in our society."
- "Most people I've met are not mentally ill. Have had their problems induced by alcohol and drugs."
- "I think people are individuals no matter what."
- "Something more severe than an everyday neurosis."
- "My ex-husband was mentally ill."

16. Don't Know/Refused

Any individual who claimed not to know how to define mental illness, or refused to answer the question, falls into this category.

Examples:

- "I don't know how to explain that."
- "I have a sister who is mentally ill. It would be hard to describe."
- "It don't ring no bell to me till I can be sure. I don't think every time they say they are mentally ill that that is true. I don't know what else to say."
- "It's an opinion they have no say so about."

APPENDIX D
Mental Health Stigma Telephone Survey Vignettes

Vignette A: Major Depressive Disorder

Ray/Sarah is a 31 year old MAN/WOMAN. For the last three weeks NAME has been feeling really down. S/he wakes up in the morning with a flat, heavy feeling that sticks with her/him all day long. S/he doesn't see a reason for getting out of bed. S/he isn't enjoying things the way s/he used to. In fact, nothing seems to give her/him pleasure. Even when good things happen, they don't seem to make NAME happy. The smallest tasks are difficult to accomplish. S/he finds it hard to concentrate on anything. S/he feels out of energy and out of steam. And even though NAME feels tired, when night comes s/he can't go to sleep. NAME feels pretty worthless, and very discouraged. NAME'S family has noticed that s/he hasn't been him/herself, and that s/he has pulled away from them. NAME just doesn't feel like talking to them.

Vignette B: Major Depressive Disorder in an Elderly Person

James/Mary is an 85 year old MAN/WOMAN. For the last three months NAME has been feeling really down. S/he wakes up in the morning with a flat, heavy feeling that sticks with her/him all day long. S/he doesn't see a reason for getting out of bed. S/he isn't enjoying things the way s/he used to. In fact, nothing seems to give her/him pleasure. Even when good things happen, they don't seem to make NAME happy. The smallest tasks are difficult to accomplish. S/he finds it hard to concentrate on anything. S/he feels out of energy and out of steam. And even though NAME feels tired, when night comes s/he can't go to sleep. NAME feels pretty worthless, and very discouraged. NAME'S family has noticed that s/he hasn't been him/herself, and that s/he has pulled away from them. NAME just doesn't feel like talking to them.

Vignette C: Schizophrenia

Robert/Roberta is a 21 year old MAN/WOMAN. Up until the last six months, life was pretty okay for NAME. But then, things started to change. NAME was convinced people were spying on him/her and that they could hear what s/he was thinking. NAME became so preoccupied with what s/he was thinking that s/he skipped meals and stopped bathing regularly. At night, when everyone else was sleeping, s/he was walking back and forth in his/her room. NAME was hearing voices even though no one else was around. These voices told him/her what to do and what to think.

Vignette D: Bipolar Disorder

Thomas/Teresa NAME is a 31 year old MAN/WOMAN. A few months ago, NAME felt really down. S/he felt like she/he had no energy, and even the smallest things, like getting dressed in the morning were exhausting. Nothing seemed to make NAME feel better, s/he was sad a lot and did not want to do any of his/her normal activities. After a few weeks, NAME started feeling better and got back to doing his/her normal activities. Now, NAME is feeling on top of the world! NAME went shopping yesterday and spent $600 on new clothes and equipment for exercising. S/he has had so much energy lately that she has decided to exercise more. NAME doesn't understand why everyone around him/her is moving so slow. Everyone keeps telling him/her that she is talking too fast, but s/he thinks they are just talking too slow. It aggravates

NAME that no one is going fast enough, no one is getting enough done at work, and NAME lets them know by accusing them of being lazy. S/he has been feeling this way for the past two weeks. For the last couple of years, NAME has had several periods of ups and downs like this.

Vignette E: Post Traumatic Stress Disorder

Dwayne/Alice is a 31 year old MAN/WOMAN. About 3 months ago, NAME was injured in a car accident on a highway. NAME'S passenger did not survive the accident. NAME has now recovered from his/her physical injuries and has returned to work. S/he has a difficult time concentrating at work, and gets aggravated very easily by things that did not bother him/her before. S/he imagines the car accident several times a day and often finds him/herself wondering why s/he survived, while his/her passenger did not. She often has nightmares at night. When NAME goes home at night, s/he always takes the side roads instead of the highway, even though the highway is faster. At night and on the weekends, NAME usually stays home and eats microwavable dinners. S/he used to love to cook fancy meals, but hasn't really felt up to it lately.