THE CONSEQUENCES OF LABELING A PERSON AS MENTALLY ILL IN AN URBAN BLACK COMMUNITY

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The problem with which this investigation is concerned is that of determining the consequences of labeling a person as mentally ill. The method of determining the consequences is accomplished through the use of a social distance scale. This assumption is made that the use of a social distance score relates the respondents' propensity to associate with specified others.

This study has a twofold purpose. The first is to determine the consequences related to labeling deviant behaviors, especially as these effects are reflected in the person who labels and defines deviant behavior. The second is to evaluate the medical model of abnormality in relation to the labeling of deviant behavior.

One hundred Ss, all Black females who were residing in a predominantly Black area in Dallas, Texas, were randomly selected to participate in the attitudinal survey. Each S was asked a uniform series of questions which tapped the respondent's attitudes toward mental illness, perceptions of mental illness, and social distancing from the mentally ill.

In order to accomplish the purposes of this study, Ss were asked to respond to questions relating to their

perspective for viewing inappropriate behavior--a medical or psychological model. Further, Ss were asked to respond to six case abstracts depicting maladaptive behaviors in regard to labeling or not labeling the case as mentally ill. The three main dependent measures then were the respondent's social distance score, labeling or not labeling, and her rank on a continuum involving a medical versus a psychological model.

The results involving the consequences of labeling a person as mentally ill were analyzed using a Student's t test. The mean social distance scores for all cases as well as for the individual case abstracts were analyzed in this manner. The effect of labeling and the subsequent degree of rejection were significantly greater than the rejection scores for the Ss who did not label the cases as mentally ill. However, this result was not consistent across each case abstract. In two of the case abstracts, the value of t was statistically significant at the .01 level, with one at the .05 level, and three above the .05 level.

In order to evaluate the relationship between rejection of the case abstracts and the respondent's predilection toward a medical or psychological model of abnormality, a Spearman rank correlation coefficient (rho) was computed. It was revealed that as the S tended toward the medical model, her social distance score also increased, which indicated greater rejection. Therefore, a tendency toward monotonicity

was revealed as being significant at the .001 level. Of the six cases abstracts, four were significant at the .001 level, one at the .10 level, and one at the .20 level.

This report concludes that the evidence seems to support the social deviance theory, which states that rejection results when a person is labeled. Furthermore, it seems that rejection may be a product of the cultural norms and expectation. Another explanation for increased rejection revolves around one's perspective of inappropriate behavior. The more one tends to be influenced by the medical model, the greater is one's unwillingness to associate with persons exhibiting inappropriate behaviors.

It is recommended that future mental health programs and education be directed toward assumptions implicit in the psychological model. However, the mental health industry can ill afford the practice of clinging solely to one model. Therefore, professionals must be ready to evaluate new models for the future and no longer ignore community consequences of their points of view.

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CHAPTER I

STATEMENT OF PROBLEM

Our American society is confronted with many complex social problems. Faced with the realities of urban riots, racial conflicts, student demonstrations and protests, and an increasing disparity between the affluent and the poor, long-standing problems such as neurosis and schizophrenia seem pale by comparison. Evidence of social unrest such as juvenile delinquency, drug abuse, school dropouts, crime in the streets, civil strife and disobedience, the sexual revolution, and many others testify to the tremendous stresses which are placed on the human condition and on the relationships between individuals and groups in society.

These social problems are a direct consequence of human behavior and its effect on an ordered society. Psychologists have been called on to "get involved" in the affairs of the community (Brayfield, 1967). Psychology is, after all, the science of behavior, and psychologists are increasingly called upon to lend their knowledge and skills in explaining society's problems.

As a result of the new involvement, psychologists find themselves searching for and acquiring new roles which lead to more active involvement and participation in community affairs. Consequently, considerable conflict and discomfort

are created in a discipline that models most of its scientific work according to the traditions of the physics laboratory, and has adopted the medical model for its clinical practices.

In the present context, the medical model is characterized by the notions that the patient should regard himself as suffering from an emergent "disease," discontinuous with his normal "problems in living," and that he should be treated by an agent with official professional credentials. However, the one-to-one, doctor-patient relationship is incongruous with present demands for involvement in community problems and new role expectations.

Psychology, as an academic discipline, is proud of its scientific bases, its insistence upon objective data and rigor, and its resistance to the styles and fads of the times. But to a greater extent than ever, psychologists who are seriously concerned with the human condition have come to believe that the time is at hand for theories based largely on studies of laboratory animals and college sophomores to be tested in a broader context. According to Iscoe and Spielberger (1969), "more and more, the value of psychological theory is being judged in terms of its predictive potential in community settings [p. 13]." Thus, the birth of a subspecialty in psychology has given rise to community psychology and community mental health.

As an area of specialized interest in community psychology, the historical origins of community mental health in

America may be traced to the earlier mental hygiene movement of the nineteenth century with its emphasis upon the humane treatment of the mentally ill, the contemporary characteristics of this rather nebulously bounded area of human concern are more immediately traceable to social, political, and scientific developments subsequent to World War II (Bennett, 1970). Community mental health has been described variously as a social movement (Brown, 1966), as a revolution in the field of psychiatry (Bellak, 1964), and as a reaction of the various mental health disciplines to certain beliefs and traditions embedded in the texture of American society (Dunham, 1965). Whatever its nature and origin, there is considerable agreement among authorities in the field that community mental health has been shaped extensively by influences external to the scientific community of professionals who man this area of specialized endeavor (Freeman, 1965; Goshin, 1966).

The social forces which have operated in American society within the past several decades to give impetus and direction to developments in the field of mental health have been multiple. These should, however, be evaluated within the larger framework of recent social changes in America, particularly that of the fairly basic shift in cultural attitudes from those supporting a laissez-faire, "self-regulating" social order to those supporting increasingly a planned welfare state--certainly one of the most pervasive

of these larger changes (Lipset, 1952). Ultimately, this change in value commitments of the public at large constitutes the prior condition and basic social context of the current "revolution" in mental health.

One of the chief social developments having direct consequences for the emergence of community mental health is the increased public awareness of and sensitivity to the mental health needs of the nation. This development may be attributed to several factors. Perhaps most prominent among these was the nation's acute awareness of the extent of psychiatric disability existing in its adult male population during and following World War II as reported by the selective service, the armed services, and the veteran's hospitals (Knee and Lamson, 1965). It came as a shock to professionals and laymen alike to discover that soldiers with a relatively normal childhood could "experience neurotic and even psychotic breakdowns, which implied that even relatively stable persons could break down under severe stress [Weinberg, 1967, p. 4]." Perhaps of equal importance in enhancing public awareness was, according to the Joint Commission on Mental Illness and Health (1961), the exposé of the deplorable condition of the nation's public psychiatric hospitals--severely neglected during the depression of the 1930's--just after the war. Lastly, efforts at broad scale public education by such organizations as the National Mental Health Association and its local affiliates, developed across the country, were

successful in giving greater visibility to the nation's mental health needs.

As the public's value commitments changed with respect to mental health services, the demand for new technologies to alleviate the social ills was embodied in social legislation. Epochal social legislation such as the Mental Health Act of 1946, enacted in response to the nation's increased concern for the mentally ill following the war, the Mental Health Study Act of 1955, which produced the Joint Commission Report, and the major community mental health legislation produced by the Kennedy and Johnson administrations, provide evidence of the nation's demands. Indeed, the Community Mental Health Centers Act of 1963, providing comprehensive services and complete coverage of the nation's population, is unprecedented as an act of health planning in the United States (Yolles, 1967).

It is not surprising that the mental health professionals, in an effort to accommodate the social changes, have found themselves beset by considerable ambiguity with regard to changing roles, by uncertainty regarding more specific goals of the new program emphasis, and by confusion and contention among the mental health disciplines regarding matters of professional domain.

Amid this controversy, concepts of community mental health range widely. At the one extreme are those who maintain that it is nothing new and simply old wine in new

bottles (Iscoe, 1970). While at the other are those who entertain almost visionary concepts of its function. The boundaries of this new endeavor are thus quite nebulous and are likely to remain so for some time to come. Certainly there is as yet no integrated theory of community mental health (Newbrough, 1964), and prevailing technologies, or modes of intervention, may be said to represent varying degrees of departure from more traditional clinical procedures (Whittington, 1965).

Pressures are now being applied to community psychology to "produce." Society wants answers for its perplexing social problems. For more than two decades, financial support has been available from one government agency or another, and especially from the Veterans Administration and the National Institute of Mental Health. Recently, the pointed question is often raised as to what all this spending has accomplished, and increasing criticism has been leveled at psychological research and practice and its limitations for amelioration of community problems. Society is now demanding a return on its investments, and rightly so.

Because of the pressure and ambiguity which besets the psychologist, he is apt to react with a flurry of activity that may or may not be based on sound evidence and thinking. Therefore, programs and procedures may be initiated with little or no thought given to the consequences which could befall the population at risk. The present study was designed to study two such consequences.

A major thrust in community mental health programs provides for the community treatment and care of the mentally ill. Indeed, the Community Mental Health Centers Act of 1963 specifically provides for inpatient care, outpatient care, and partial hospitalization services for community residents, the center being located within the community (Smith and Hobbs, 1970). In other words, individuals with mental disorders can remain in the community close to friends and relatives.

Another vital area of concern deals with secondary prevention, the early recognition of symptomatic behavior of mental illness by the population through education. Being able to perceive and identify mental illness quickly could lead to earlier treatment and a better chance of achieving an adequate coping level. But what are the consequences of labeling a person as mentally ill, whether the person attaching such a label is a mental health professional, significant other, or slight acquaintance? Does such a label affect the attitudes and perceptions of individuals making that assessment?

One can speculate that the label of mental illness has little or no effect on anyone involved. However, an individual who is labeled mentally ill may be rejected and avoided by the community (Becker, 1963; Lemert, 1951; Schur, 1971).

If it happens that rejection is a consequence of labeling, then a community mental health program designed to

treat mental illness in the community might encounter strong resistance. The community at large might feel quite "uncomfortable" with mentally ill individuals remaining in the community. Hopefully, these questions can be resolved and the consequences evaluated.

During the past two decades several studies have been conducted to assess the ability of the public to recognize varying types of deviant behavior as mental illness. Most of these investigations used three or more of the illustrative case abstracts which were developed by Star (1955) in the early 1950's for a nationwide attitudinal survey conducted by the National Opinion Research Center. The abstracts describe varying forms of mental illness including paranoid schizophrenia, simple schizophrenia, alcoholism, anxiety neurosis, compulsive phobic personality, and juvenile behavior disorder. Since the first study by Star, an increase in the public's willingness or ability to correctly identify the case abstracts as mental illness has been seen. These abstracts are reproduced in Appendix B.

With the exception of two studies (Phillips, 1966; Bentz and Edgerton, 1971), there has been no empirical research undertaken which examines the significance of this change for acceptance or rejection of the mentally ill. Although the present study is not a replication of these two studies, it is concerned with the same idea of whether the increased ability of the public to label or identify mental

illness depicted in the case abstracts is associated with the acceptance or rejection of the mentally ill.

Persons labeled as mentally ill have been typified as engaging in deviant behavior (Lemert, 1967). Deviance has been characterized as departure from the behavioral norms of a particular group or society (Webster's Dictionary, 1965). As Becker (1963) suggests, "deviance is not a quality of the act the person commits, but rather a consequence of the application by others of rules and sanctions to an 'offender.' The deviant is one to whom that label has successfully been applied; deviant behavior is behavior that people so label [p. 9]." Becker's position is very similar to the theory of societal reaction to deviance, which states that deviance from socio-cultural norms is punished by rejection and subsequent social isolation of the deviant (Kitsuse, 1962).

Since mental illness more often than not manifests itself in some degree of deviation from the community norms, those persons labeled as "mentally ill" will also be subjected to rejection and isolation. It has been argued that mental illness should be considered a social status rather than a disease because the definition of symptomatic behavior of mental illness is usually dependent upon social rather than medical contingencies (Scheff, 1964). In other words, mental illness as a social status is <u>ascribed</u> rather than <u>achieved</u>.

Considerable empirical data has been produced which supports the societal reaction theory toward mental disorder,

with the concomitant rejection and isolation. For example in 1950, Star (1955) directed a National Opinion Research Center study of attitudes toward mental illness. A nation-wide sample of adults was asked, among other things, to react to brief descriptions of the behavior of six fictitious individuals. Each description was designed, with psychiatric consultation, to illustrate a different type of psychological disorder. (These six cases can be found in Appendix B.)

The interviewees were asked to state, in each case, whether there was anything wrong with the person and if so, what. Was it mental illness? Was it serious?

Only in the case of the paranoid schizophrenic was a majority (75 per cent) of the people interviewed able (or willing) to recognize mental illness. In the other five instances, the recognition ranged from 34 down to 7 per cent.

Star (1955) concluded on the basis of this study that " . . . people are afraid of psychotics and afraid of being infected by their irrational way of thinking. So they keep what they call mental illness at arm's length by emphasizing the difference between themselves and 'crazy people.' [p. 5]" She continues " . . . mental illness is a very threatening and fearful thing and not an idea to be entertained lightly about anyone. As both our data and other studies make clear, mental illness is something people want to keep as far from themselves as possible [p. 6]."

Cumming and Cumming (1957) obtained essentially the same results reported by Star. The study demonstrated the inability of an intensive educational program in a Canadian community to alter attitudes toward the mentally ill. The attitudes exhibited by the community led to a patterned response of "denial, isolation and rejection [p. 119]."

A Social Distance Scale was used to tap the willingness of the community to associate with persons labeled as mentally ill. The Scale contains items of varying degrees of closeness of association. (The Scale appears in Appendix C.)

The Scale consisted of five questions which can be ranked as to the closeness of association required to answer a particular question in the affirmative. The question indicating the most distant association asked the respondent if he would be willing to have such a person described in the case abstract as a neighbor. The next three questions ranged from association in a club or organization, to a job situation, to being willing to rent a room to the person in one's own home. The fifth question represented the closest association in asking whether or not the respondent would allow his child to marry the person described in the case abstract.

The Cummings (1957) reported that "the average person in this community is willing to live in the same neighborhood with former mental hospital patients, but he stops short of 'rooming with a former mental hospital patient' and denies

willingness for any closer association [p. 105]." They continue by saying that once ". . . the label 'mental illness' is applied--society must respond with isolation against the threat of behavior which is ungoverned by the rules [pp. 128-129]."

Similarly, Nunnally (1961), on the basis of a questionnaire survey in three United States' cities, confirmed what the above two studies found--the general public regards the mentally ill with fear, distrust and dislike.

In both the Star (1955) and Cumming (1957) studies, an inability or unwillingness on the part of the public to recognize these case abstracts as mental illness was reported (Phillips, 1966). Only the most extreme case, the paranoid, was identified by a majority of people as indicating mental illness. Thus, during the 1950's it was generally accepted that the public's feelings about mental illness were characterized by anxiety, rejection, misinformation, and an inability to recognize behaviors indicative of mental illness. But inability or unwillingness to identify a case abstract as mentally ill in itself tells us nothing about a respondent's readiness to tolerate the behavior described.

In an attempt to study the public's readiness to tolerate behavior symptomatic of mental illness, Phillips (1966) conducted research designed to study the public's acceptance or rejection of such behavior. Drawing a sample from a southern New England town, the research design used four of Star's

case abstracts, the paranoid, the simple schizophrenic, the depressed neurotic and the phobic-compulsive. Phillips offered no explanation regarding his rationale for using only four cases rather than all six. The sample was asked what degree of association it would tolerate with persons exhibiting such behavior. The sample was not asked to identify the cases as "mentally ill."

Phillips (1966) compared the mean social distance scores of the above mentioned case abstracts with an abstract depicting a normal individual. An analysis of the data showed that respondents were much more intolerant of behavior indicative of mental illness than they were toward the normal individual. The respondents were most intolerant of the paranoid. Phillips (1966) concluded "that the public . . . are frequently unwilling to associate with mentally ill individuals. Although it was not possible to ascertain whether or not they could identify them as mentally ill, the respondents clearly differentiate among different types of mental disease. This is indicated by their relatively strong rejection of the paranoid schizophrenic compared to the low rejection of the phobic-compulsive [p. 762]."

The results of other studies suggest that a change in the public's ability to identify these case abstracts as mental illness may be taking place. In 1960, Lemkau and Crocetti

(1962) studied a cross-section of adults in Baltimore, Maryland. To their surprise, respondents were much more likely to identify three of the case abstracts as mentally ill than were Star's nationwide sample in 1950. In fact, 91 per cent of the Baltimore respondents saw the paranoid as mentally ill; 78 per cent judged the simple schizophrenic to be mentally ill; and 62 per cent labeled the alcoholic as mentally ill. These are increases which range from 26 per cent to 34 per cent, with the proportions more than doubling for two of the three cases.

On the basis of these results, Lemkau and Crocetti (1962) expressed "that popular attitudes towards mental illness and the mentally ill are in fact changing, and that the present study, being among the most recent, reflects this change [p. 698]." They further suggest that their results indicate a triumph of mental health education efforts in recent years.

There is, however, at least one difficulty with these inferences from their results. In contrast to Star's (1955) study, Lemkau and Crocetti (1962) used only three of the six case abstracts, and, more important, these three were used with the order greatly changed from that used by Star. Therefore, the contrast between the two sets of findings may be a methodological artifact.

Yet the Baltimore respondents, in fact, were about as likely to see mental illness in these three cases as were

the community leaders studied by Dohrenwend, Kolb and Bernard (1962) in a section of New York City in 1960. The researchers used all six case abstracts. They reported, ". . . all saw mental illness in the description of paranoid schizophrenia; 72 per cent saw it in the example of simple schizophrenia; 63 per cent in the alcoholic; about 50 per cent in the anxiety neurosis and in the juvenile character disorder; and 40 per cent in the compulsive phobic [p. 685]."

In a later study of a cross-section of adult residents in the Washington Heights area of New York City, Dohrenwend and Chin-Shong (1967) found that the respondents were far more likely to identify the case abstracts as mentally ill than were the respondents in the previous studies of the 1950's. However, the obtained percentages were somewhat less than those obtained in the urban leaders study (Dohrenwend et al., 1962). The researchers (Dohrenwend and Chin-Shong, 1967) concluded that "since Star's research in 1950, mental health education efforts may well have led the public to extend the label of mental illness to wider varieties of behavior [p. 429]."

In reviewing the studies of the last two decades, a definite change in the public's attitudes toward and knowledge about mental illness can be traced. The public's ability to recognize mental illness, and so label behavior as such, has increased during this same period.

The first attempt to study the apparent changes in recognition ability and the consequences which may result was undertaken by Bentz and Edgerton (1971) in the late 1960's, using a random sample of 1,405 respondents from two predominantly rural North Carolina counties and one rural county in Virginia.

The research procedures used four of Star's (1955) case abstracts, the simple schizophrenic, the alcoholic, the anxiety neurotic, and the acting-out child. The respondents were asked whether or not the described behavior was indicative of mental illness. A social distance scale was then used to ascertain the degree of closeness of association the respondents were willing to have with such a person.

The mean social distance scores were computed for both groups, those who stated the case described was mental illness and those respondents who did not make such a judgement. Bentz and Edgerton (1971) found no significant difference between the group means. Therefore, they concluded that they had ". . . found no evidence to support the generally accepted view that identification or labeling a person as mentally ill will result in a greater degree of rejection and isolation than if such a distinction is not made. On the contrary, our data strongly support the proposition that persons who attach the label of mental illness to the previously described behaviors do not differ significantly from persons not using this label in terms of their willingness to interact at

various levels with the mentally ill [p. 32]."

The results of the study may have been affected by the methodology employed by the researchers. Only four of Star's six case studies were used and the order of their presentation was altered. Bentz and Edgerton (1971) presented the case illustrating simple schizophrenia, then the alcoholic, then the anxiety neurotic, the last case being the acting-out child. The elimination of the paranoid case may have affected the results in the direction reported. How does the more severe form of mental illness affect respondents' willingness to associate with another mentally ill person? Also, a sensitivity to order of presentation could lead to confusion about what is and what is not mental illness.

Therefore, the findings reported by Bentz and Edgerton may be the result of methodological difficulties. The present research provided for the inclusion of all six case abstracts presented by systematically alternating the order of the case descriptions in the interviews with a sample of residents of an urban Black community.

The problem of this study concerned the relationship that existed between labeling a person as mentally ill and the degree of subsequent acceptance or rejection reported by the person making such a judgement. Furthermore, data was obtained which made it possible to determine the respondents tendency to view psychological problems from a medical or

psychological perspective. These relationships were investigated using a sample population drawn from an urban Black community. The rationale for selecting a Black population relates to the published findings of Hollingshead and Redlich (1958), which suggested that a higher proportion of mental illness occurs in the lower socioeconomic classes. Likewise, the National Institute of Mental Health (1969) has called for a concerted effort and improved programs to deal with the increase in mental health programs, especially among urban Blacks residing in deprived areas (Hersch, 1969).

The purposes to be served by this investigation were to evaluate and extend current theory and empirical knowledge about the relationships in question, and to provide data that can be used by professionals in evaluating current methods and approaches. The relationships presented above may, at first inspection, seem unassuming and nonessential. However, the present research attempted to evaluate the theoretical model which underlies the term, mental illness. The use of mental illness as a label is based largely upon the medical model of abnormality. The medical model implies an underlying diseaselike process for psychological disorder along with many concomitant assumptions about the mentally ill. In this respect the medical model can be equated to past-oriented psychodynamic models. For example, psychological problems such as fear of interpersonal relations or alcoholism are said to be only symptoms of a more basic

disease, be it an organic disorder or a repressed conflict. Conversely, the psychological model asserts that maladaptive behavior does not usually result from a physical disease nor does it typically require the uncovering of repressed conflicts, but that it is acquired by the same types of normal learning processes with which all persons adapt to life. Thus, it is more accurate to state that the purposes of this study were directed toward an evaluation of the medical and psychological models of abnormality as they might be applied in mental health programs.

In order to solve the problem and achieve the purposes of this study, a sample of respondents drawn from an urban Black area were assessed by means of a standard interview schedule for determining the ability to recognize mental disorder, the predilection toward a medical or psychological model, and the degree of acceptance or rejection measured by a social distance scale. Statistical procedures were applied to these data to determine the degree of association between recognition and labeling mentally ill and the degree of acceptance or rejection contingent upon this judgement. Furthermore, the data was analyzed to ascertain the degree to which respondents, tending toward a medical or psychological model, demonstrated a tendency to reject or accept persons labeled as mentally ill.

Hypotheses

1. There is no significant difference between respondents who identified the case abstracts as mental illness and those who did not make this judgement with respect to their mean social distance scores.

2. There is no significant relationship between a respondent's preference for a medical or psychological model and her mean social distance score.

Since theoretical concepts have not evolved which provide sufficient foundation for positing directionality in this hypothesis, it is assumed that the respondent's preference for a medical or psychological model may not have an effect on acceptance or rejection of the behaviors described in the case abstracts.

CHAPTER II

METHOD

The design of the study specified the distribution of the questionnaire, appearing in Appendices A, B, and C, to members of an urban Black community in Dallas, Texas. The area is situated in West Dallas which is characterized by populations typified as occupying lower socioeconomic status. Specifically, the population selected for study inhabit a housing project managed by the Dallas Housing Authority and known as the Edgar Ward Housing Project. The total population of the area as reported by the 1970 census was approximately 7,732 of which 2,891 were adults.

The area's economic base consisted almost solely of Federal aid in the form of Aid to Families with Dependent Children (A. F. D. C.). The average annual income was reported to be well below four thousand dollars per family.

Furthermore, the area consisted of a Black population estimated to be 98 per cent of the total population, with the other 2 per cent consisting of whites and Mexican-Americans. The median education of the adult inhabitants of the area was also estimated to be at the ninth grade level.

The sample selected from the population just described consisted of 100 randomly selected Black females who presented themselves at a pediatric out-patient clinic. The

clinic serves the entire Edgar Ward Housing Project, as its specified target area. Therefore, every resident has the opportunity to avail himself of the free medical, social, and psychological services at the clinic.

For a period of three weeks, approximately eight mothers were randomly selected from the appointment list each day to serve as Ss to whom the questionnaires were administered. Once the S arrived at the clinic, each of them was administered the structured interview schedule individually. Furthermore, the entire schedule was read to the respondents, who were asked to respond verbally.

The Schedule

The interview schedule in designed to elicite the following information and opinions:

1. The attitudes of the respondents toward mental illness and the mentally ill.
2. Perceptions of mental illness.
3. The extent of social distance from the mentally ill in the community.

In order to measure attitudes toward mental illness, the Attitudes About Mental Illness Scale (AAMIS) was employed (Pennal, 1972). The scale was developed for the purpose of measuring attitudes about mental illness with regard to discerning a respondent's rank on a continuum involving the medical model versus the psychological model. Furthermore, it was hypothesized that, as a person received more

psychological training, his views would slant more toward a psychological model.

Pennal (1972) reported that the 35 items constituting the AAMIS were selected, initially, from approximately 45 items, which were selected for their obvious face validity. Additionally, a validity study was conducted which demonstrated that as a person advances in psychological study, especially to the graduate level, he is considerably more apt to tend toward the psychological model than a person who has received less psychological training.

In refining the scale from 45 to 35 items, the test reliability (coefficient alpha) was increased from .8635 to .8697. Therefore, reliability was optimized by decreasing the length of the scale to its present 35 items.

The AAMIS was administered to the 100 Ss who were randomly selected for the study. Each S was asked to respond to each of the 35 statements by verbally replying with a choice of possible answers on a 5-point scale ranging from strongly agree to strongly disagree. Therefore, a S could have scored from one to five on each item, depending on the numerical value of his answer. Further, high scores indicated attitudes slanted toward the medical model, low scores indicated attitudes slanted toward the psychological model. On the 35-item scale a score of 35 indicated pure psychological model, 105 indicated neutral, and 175 pure medical model.

In order to test for a relationship between the ability to identify mental illness and the degree of social acceptance or rejection of the mentally ill, each person interviewed was asked to respond to the six case abstracts developed by Star (1955). Each S was asked whether or not she viewed the case abstract as indicative of mental illness.

After reading each case abstract, the respondent was asked a uniform series of questions. The questions make up a social distance scale, indicating how close a relationship the respondent was willing to tolerate with the individuals in the case abstracts. The scale used here is similar to the social distance scale developed by Cumming and Cumming (1957). Phillips (1963) developed the scale which was applied to this study.

The social distance scale consists of the following five items: (1) "Would you be willing to have a person like this as a neighbor?" (2) "Would you be willing to have someone like this join a favorite club or organization of yours?" (3) "Would you be willing to work on a job with someone like this?" (4) "If you had a room to rent in your home, would you be willing to rent it to someone like this?" (5) "Would you discourage your children from marrying someone like this?" The order of these items duplicates the order of "closeness" represented by the scale (Phillips, 1963). However, the order of presentation of the questions was systematically varied with each case abstract as the questions were read to the Ss.

The range of possible scores was from zero (when all items indicated acceptance) through five (when no items indicated acceptance). Phillips (1963) conducted a test of reproducibility which resulted in a coefficient of .97, indicating that the scale met the acceptable standards established by Guttman (Stouffer, Guttman, Suchman, Lazarsfeld, Star, and Clausen, 1950), indicating that it is a uni-dimensional scale.

In computing a score for each respondent, item five was reversed, so that all items would be positive with all negative responses being scored. Thus, if a respondent obtained a scale score of zero, this indicated that she was willing to tolerate having her child married to such a person described, as well as all other relationships. Therefore, the lower the score, the greater the degree the respondent was willing to interact and associate with persons described in the case abstracts. Conversely, the higher the score, the greater the degree of rejection of the person defined as mentally ill.

Upon completion of these basic computations, the task of comparing groups proceeded. Initially, the comparison dealt with the group who did not identify the case abstract as mentally ill, and another group who indicated that the same case abstract represented mental illness. For each of the 100 Ss, a social distance score was obtained for each case abstract, as well as for all cases combined. Thus, for

each case abstract, there were two social distance scores--one mean social distance score for the respondents who perceived mental illness and another score for the group who did not make such a judgement. In order to test the first hypothesis, a t test was used for all case abstracts, along with each one singly, in a comparison of the two groups. The level of significance to reject the null hypothesis was set at the five per cent level.

A Spearman rank-order correlation (rho) procedure was employed to test the second hypothesis. A Ss score on the AAMIS constituted the ranked variable against which the Ss mean social distance score for all six case abstracts was correlated. Furthermore, in order to ascertain the degree of monotonicity for each case abstract, each Ss AAMIS score was compared to their respective social distance scores for the six case abstracts. In regard to testing the significance of the correlation coefficients, a t test was used to determine what decision should be made regarding acceptance or rejection of the hypothesis.

CHAPTER III

RESULTS

A two-sample Student's t test using the Miami Biometric Laboratory Program (Clyde, Cramer, and Sherin, 1966) was computed with fourteen dependent measures on the IBM 1620 System at the Computer Center of the University of Texas at Dallas Southwestern Medical School.

The difference of means test was performed for all the case abstracts, using the mean social distance score for those respondents who identified the case abstract as mental illness and those who did not. Furthermore, t tests were carried out for each of the six case abstracts. In Table 1 the results of these analyses are shown.

The data permit the rejection of the null hypothesis in regard to the difference between the mean social distance of all cases combined ($t = 9.90$, $p < .01$). Consequently, evidence was found to support the generally accepted view that identification or labeling of a person as mentally ill did result in a greater degree of rejection and isolation than if such a distinction is not made. However, in regard to the six individual case abstracts, data from only three of these allow the rejection of the null hypothesis.

A closer look at the results reveals that the mean social distance scores seem to increase with what may be

TABLE 1

Relationship between Mean Social Distance Scores and Identification of Case Abstracts as Mental Illness

Case Abstract	Identified as mentally ill	Not identified as mentally ill	t	P less than
Paranoid schizophrenic	3.97 (89)	3.00 (11)	3.21	.01
Simple schizophrenic	3.70 (77)	3.08 (23)	2.61	.05
Obsessive compulsive	3.42 (71)	2.79 (29)	2.95	.01
Anxiety neurotic	2.38 (53)	2.40 (47)	-0.15	.75
Alcoholic	2.10 (51)	2.16 (49)	-0.33	.65
Acting-out child	1.55 (29)	1.18 (71)	1.93	.10
All cases	3.13 (370)	2.12 (230)	9.90	.01

perceived as an increase in the severity of mental disorder. Indeed, the paranoid schizophrenic was labeled as mentally ill by 89 per cent of the respondents, while also being rejected to the greatest extent ($\bar{x}$ = 3.97, t = 3.21, $p < .01$). Likewise, the simple schizophrenic and the obsessive-compulsive were characterized by significant differences between social distance scores which indicated greater rejection by the respondents labeling these cases as mentally ill. Conversely, the anxiety neurotic, the alcoholic, and the acting-out child were typified by lower mean social distance scores across groups, and there was no significant difference between groups.

The case abstracts which were identified as mentally ill extended from 89 per cent for the paranoid schizophrenic to 29 per cent for the acting-out child. Curiously, the acting-out child was identified as mentally ill to a much lesser extent than the other case abstracts.

Another important factor relating to the propensity to label or not label the case abstracts as mentally ill pertains to the reasonably consistent property of the variances to differ in one direction. (See Table 2.) As evidenced by these data, the respondents who identified the case abstracts as mentally ill tend to demonstrate a smaller degree of variance than those respondents who did not use the mental

TABLE 2

Relationship between the Variances and Identification of Case Abstracts as Mental Illness

Case Abstract	Identified as mentally ill	Not identified as mentally ill	*F*	P less than
Paranoid schizophrenic	0.828	1.400	1.69	.10
Simple schizophrenic	0.949	1.083	1.14	.20
Obsessive compulsive	0.790	1.312	1.45	.10
Anxiety neurotic	0.586	1.072	1.83	.02
Alcoholic	0.770	1.181	1.53	.10
Acting-out child	0.899	0.695	1.29	.20
All cases	1.475	1.478	1.00	.10

illness label. Evidence for this inference was provided by observing the extent of the difference between the variances of all cases (F = 1.00, 37/61 df, $p < .10$), which indicated nonsignificant differences between the variability in the social distance scores of both groups of respondents. However, the anxiety neurotic is the only single case abstract which indicated a significant F score (F = 1.83, 46/52 df, $p < .02$).

Analysis of the AAMIS scores in relation to the respondents' mean social distance score for the six case abstracts was carried out by using the Spearman rank correlation procedure. The analysis revealed that Ss scoring higher on the AAMIS also reported significantly higher mean social distance scores (rho - .476, 98 df, t = 5.372, $p < .001$). (See Table 3.) Therefore, a significant tendency toward monotonicity was noted as a result of the analysis. In other words, the results were significant enough to reject the hypothesis that the true agreement in ranks was zero.

Further, a correlation matrix showing the relationship between the AAMIS scores and the social distance scores of each case abstract appears in Table 3. Scattergrams graphically depicting the relationship for each case abstract appear in Appendix D. These data indicate a significant concordance between the scores for the paranoid schizophrenic, simple schizophrenic, obsessive compulsive, and anxiety

TABLE 3

Spearman Rank Correlation between AAMIS Scores and Social Distance Scores

Case Abstract	rho	df	t	P less than
Paranoid schizophrenic	.608	98	6.05	.001
Simple schizophrenic	.576	98	5.76	.001
Obsessive compulsive	.332	98	3.30	.001
Anxiety neurotic	.402	98	4.00	.001
Alcoholic	.160	98	1.56	.20
Acting-out child	.169	98	1.68	.10
All cases	.476	98	5.37	.001

neurotic. Therefore, the two rank orders of these case abstracts demonstrate a tendency of the two scores to be similar and reveal an increasing monotonicity.

CHAPTER IV

DISCUSSION

The results of this study clearly indicate a rejection of the first hypothesis, as it relates to the consequences of labeling behavioral characteristics as mental illness. However, some inconsistency arises as a result of only three of the case abstracts attaining significant levels of mean differences. Furthermore, these three cases were identified as mentally ill considerably more often than they were not so labeled. Conversely, there appeared to be no significant consequences attached to labeling the other three cases as mentally ill.

In order to derive some meaning from these findings, one must examine the data in the light of Black cultural norms and expectations. First of all, the Black females composing the sample are beset by many stresses and problems with which they are expected to cope. Along with being required to care for an average of four or five children without having a father present, in most instances, these women have to cope with the very present realities of financial, social, and psychological deprivation. Therefore, one's perception of maladaptive behavior and the concomitant reaction to that behavior could certainly be predisposed toward a view which is most consistent with their cultural

expectations. In other words, behaviors which may be defined as maladaptive by one culture or socioeconomic class may, in fact, provide an effective means for coping with life stresses which are imposed upon another socioeconomic class.

If this assumption is correct, then a discussion of the results can proceed, and might possibly explain the seemingly contradictory results. First of all, the respondent's reaction to the paranoid schizophrenic was marked and almost unanimous. Because of the threatening, antisocial behavior coupled with the uncertainty of the behavior's occurrence, most of the respondents labeled the paranoid schizophrenic's behavior as mentally ill, preferring not to associate with a person exhibiting this type of behavior except as a neighbor or similar acquaintance.

Conversely, the case abstract of the simple schizophrenic presented no real threat, but exhibited rather withdrawn behavior. Fully two-thirds of the respondents labeled the case as mentally ill, with most of these preferring not to associate too closely with a person as described in the case abstract. Possibly, the reaction to the behavior was a product of the environmental demands placed upon these women. It seems plausible that the respondents recognized that withdrawn behavior, especially if exhibited in the home, is most maladaptive in their environment. In order to deal with their children and other necessities, the Black mothers have to be most aggressive in exerting considerable energy to maintain control of her life situation.

From these observations it was evident that this population did not demonstrate a greater or lesser degree of tolerance toward either the antisocial or withdrawn behavior. This conclusion contradicted, to some extent, the findings reported by Dohrenwend and Chin-Shong (1967), who commented that lower-class respondents were more apt to ignore the pathology of withdrawn behavior.

Similarly, only one-third of the respondents labeled the acting-out child as mentally ill, with the majority of the respondents admitting to the greatest degree of acceptance as opposed to the other cases. Again, the environmental realities seem to dictate the respondent's reaction, since many of their children exhibited the same characteristics as described in the case abstract. Incidentally, many of the Ss related that they were experiencing the same problems described in the case abstract with at least one of their children.

Consequently, one conclusion emerges which deals directly with the resultant consequences of labeling behavior as mental illness. The effect of labeling seems to relate most closely to the behaviors described in the case abstracts and to their prevalence within the immediate environment. The respondents' reactions to the case descriptions seemed to be biased by cultural relativity.

A further example of the cultural relativity position is reflected in the respondents' reaction to the alcoholic

case abstract. Whereas Bentz and Edgerton (1971) reported that greater than three-fourths of their rural, predominantly white, respondents recognized and labeled the alcoholic as mentally ill, only one-half of the Ss in the present study labeled the alcoholic as mentally ill. Furthermore, Bentz and Edgerton (1971) found that the two mean social distance scores differed significantly, with the alcoholic being rejected to a greater extent by the respondents who labeled the case abstract as mentally ill. However, the urban Blacks demonstrated a lack of social discrimination for the alcoholic regardless of whether or not they labeled the alcoholic as mentally ill. Indeed, many respondents proffered information to the effect that they had close acquaintances and husbands who could be described as being quite similar to the alcoholic case abstract.

Therefore, it could be concluded that the Black women saw the behaviors described in the alcoholic case abstract as normative behavior, necessary for some, especially males, to cope with the environmental stresses. Moreover, the reactions to the other case abstracts also seem to follow the same reasoning relating to the cultural relativity of defining behaviors as adaptive or maladaptive.

However, another explanation is possible, which relates to the respondents' view of mental disorder. The data suggest that as a S tends toward a medical model perspective of mental disorder, she also tends to reject, to a greater

extent, persons presenting maladaptive behaviors. Conversely, as a respondent approaches a psychological model perspection, a significant tendency toward a greater tolerance of these behaviors was noted. These findings are of considerable importance to the mental health professionals and to the planning of emergent approaches to mental health problems.

It would seem that, after analyzing the data, a case could be made for abandoning mental health education based upon the medical model, at least for populations similar to the urban Black sample. Indeed, mental health education has been directed toward informing the public that mental disorder and maladaptive behaviors are a sickness like any other disease (Sieveking, Doctor, and Campbell, 1972). However, educating the public toward a medical model perspective has certainly played a very useful part in the history of attempts to deal with "strange" behavior. Significant advances have been made since the era of demonology and exorcism as means of dealing with mental problems. The medical model has fostered the process of getting the mentally ill out of the "closet" and into the realm of scientific endeavor. Modern chemotherapy has proven to be most effective in reducing the length of hospitalization for the mentally ill. Therefore, many "mental patients" are maintained in the community, which leads to breaking down the barriers of isolation further.

However, as the present study reveals, the medical model has not fostered a greater acceptance or willingness to associate with persons exhibiting inappropriate behaviors. One implication of the medical model holds that persons who behave abnormally are not responsible for themselves since they are sick, and that they should be sheltered from the consequences of their behavior. This implication raises legal questions and also makes it logically difficult to assist disturbed persons to meet their social obligations rather than be sheltered from the familial and community forces which serve to socialize more adaptively behaving persons.

In order to gain some perspective in dealing with the medical model dilemma, society's manner of dealing with the issue of mental disorder must be viewed as an evolutionary process. Initially, no apparent cause could be found for "strange" behavior. Therefore, society invoked religious beliefs and relied on religious practices to handle unexplainable behaviors. Subsequently, as medical science gained in prestige and purview, a medical explanation was sought to deal with disturbed behavior. A major breakthrough came when medical science discovered the spirochete, which was found to cause the general paresis and mental deterioration, accompanied by rather bizarre behavior, in syphilitic patients. A direct cause and effect relationship was established which explained bizarre, inappropriate behaviors of some individuals. However, much to the dismay of many

practitioners, this discovery remained the only significant contribution relating to the physical cause of "strange" behavior.

Since the advent of effective psychotropic medication, the medical model remains as the predominant perspective from which mental disorder is viewed. Furthermore, the medical model has played a vital role in fostering and supporting a humanistic approach to persons exhibiting inappropriate behavior as well as setting the stage for the emergence of an alternative model. Nonetheless, the medical model may have outlived its usefulness.

As a part of the evolutionary process, a relatively new approach and perspective has come out of the decades of formulating and evaluating learning theories. A new model has evolved which rivals the medical model as a means of explaining the cause and course of mental disorders. The psychological model reflects the position that maladaptive behavior is not caused by an underlying disease process, but rather is a product of a person's social history of interaction and reinforcement. Likewise, the psychological model states that overt, inappropriate behaviors are the real problem, and that these behaviors will be maintained as long as the environment reinforces them.

The present study reveals a significant relationship which exists, as well as leading to an implication that society and mental health professionals should now shift

their emphasis toward the psychological model. However, it is one thing to criticize current models of abnormality and another to support alternatives.

Nevertheless, the psychological model (for example, Ullmann and Krasner, 1969) is more firmly based empirically and avoids some of the negative community consequences of the medical and the traditional psychodynamic models. The findings of psychological research, especially in the areas of learning and attitude change, are leading to the development of procedures which can be applied within the psychological model. These procedures often deal with everyday behaviors rather than with repressed conflicts. Thus they can more readily be administered by community resources, such as teachers, parents, and police, as the disturbed person remains in his customary surroundings. Even when treatment by a specialist is required, its duration will often be shorter than that dictated by the medical or the psychodynamic models.

Additionally, since abnormal behavior is said to result from normal learning processes, deviant individuals need not be labeled as diseased or as different in kind from normally behaving people. The psychological model does suggest that a deviant person should not be overly protected from the consequences of his behavior so that he not be rewarded for retaining the behavior. Instead, the consequences and antecedent conditions accompanying the deviant behavior should be altered.

Finally, as a result of the findings of this study, the Black women who view the case abstracts with the psychological model also tend to be less distancing in relation to individuals exhibiting inappropriate behaviors to a significantly greater extent than persons operating under the medical model.

In relating these findings to research pertaining to community mental health programs, clearly it is imperative that the process of labeling disturbed individuals, especially Blacks, by mental health professionals must necessarily be reconsidered. The implications of professionally defined deviant behaviors, as opposed to relying on the "community screen," could lead to mental health professionals being portrayed as social control agents (Kellert, 1971). In other words, inappropriately labeling culturally normative behaviors as deviant is a most questionable practice in the light of the findings derived from this study. Therefore, since the definition of behavior as being deviant seems to be relative to the Black cultural expectations, research must be conducted which taps the community's attitudes toward certain behaviors. Further research could determine the validity of this inference by conducting cross-cultural research with populations matched on relevant variables such as education, income, and others.

Future mental health programs would seem to profit from using the psychological model as their theoretical base. The

community can be viewed as the source, exacerbator, and potential alleviator of social deviance (Golann, 1970). Therefore, mental health programs can scarcely afford an approach which continues to label individuals as well as clinging to the medical model, especially when the programs are directed toward a disadvantaged Black community.

Ulmer and Franks (1973) have suggested a unique approach to the delivery of mental health services. As they see it, mental health facilities should be viewed as essentially social training institutions for disturbed and disturbing persons with limited social competence. Furthermore, they advocate changing the name of so-called mental health programs to behavioral, social training programs and operating under the assumptions implicit in the psychological model.

The issues raised by this paper suggest consequences for individual reactions to persons with problems, and for the policy of the mental health industry to label deviant behaviors. They suggest also a needed evaluation of mental health campaigns, which have to date been based largely upon the medical model. This model might have little effect in decreasing feelings of repulsion toward the seriously disturbed, but have more effect in portraying them as physically diseased and in delimiting the types of community resources that are marshalled to deal with their problems. Since no model has incorporated all relevant findings, none can claim complete generality, and the advocates of models cannot

ignore community consequences of their points of view. The public's educational level is increasing, as is its consumption of mass media, which appear to be becoming more aware of intellectual issues. Therefore, future research should be directed toward determining the generality of the present finding, especially in regard to sampling other cultural and socioeconomic groups.

As a result of the present study, it could be inferred that the psychological model is the next stage of development in society's long history of attempts to deal with psychological problems. The research indicates that the set of assumptions characterized by the psychological model may provide the necessary theoretical base upon which emergent approaches to mental health problems may be framed. However, even though the exigencies of the psychological model have been cited, the mental health industry can ill afford the luxury of clinging solely to one model. For how one defines a problem limits one's view of the relevant variables, restricts the manner in which issues are handled, and narrows the perspective of viewing future models.

APPENDIXES

APPENDIX A

ATTITUDES ABOUT MENTAL ILLNESS SCALE

Respond as to how you feel about each statement as follows:

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
1	2	3	4	5

1. Mental illness is just another name for peculiar behavior.
2. The best treatment of mental illness requires indirect treatment of the underlying causes.
3. An alcoholic is not a sick person like someone who has heart trouble.
4. Most insanity could be cured by drugs if we only knew which drugs to use.
5. Schizophrenia is probably not a metabolic disorder.
6. There is no underlying disease that causes insanity.
7. A tendency toward craziness cannot be inherited.
8. Mentally ill people really act the way they do because they have a defective brain.
9. The strange behavior of a person who is mentally ill is an outgrowth of his illness.
10. If the symptoms of a mentally ill person are eliminated, he is no longer mentally ill.
11. Before mental illness can be cured, its underlying cause must first be discovered.
12. Personality is largely determined by hereditary factors.
13. Insanity is not due to a defective brain.
14. A crazy person is not sick.
15. Symptoms of mental illness are the real problem.

16. Schizophrenia is not an inherited disease.

17. The chief value of drugs in treating mental illness is that they can get at the roots of the illness.

18. Basically, mental illness is an illness like any other.

19. Defects in a person's nervous system do not cause mental illness.

20. The cause of mental illness may be found in the blood stream.

21. The real trouble in mental illness is not due to something inside a person that causes him to do strange things.

22. Mental illness cannot be cured with drugs.

23. A person is more likely to become insane if he received a hard blow to the head as a child.

24. There is no such thing as insanity; there is only strange behavior.

25. No matter what changes may occur in an alcoholic's life, his body can never resist drunken binges if he so much as takes one drink.

26. An ultimate cure for mental illness will not be found until our knowledge of the effects of drugs on the body is complete.

27. Ultimately, some brain defect will be discovered in all cases of personality disorder.

28. It is possible that some schizophrenics hide their illness by acting normally for long periods of time.

29. The mentally ill person's peculiar behavior is not due to some underlying cause.

30. Drugs are the only kind of therapy which can be effective in curing certain types of mental illness.

31. No real cure of insanity can be brought about by brain surgery.

32. An organic cause for mental illness will not be found.

33. In treatment of a mentally ill person, the only thing that counts is a change in his present behavior because that is his real trouble.

34. People who are severely obese are probably suffering from a glandular problem.

35. Psychiatrists and other physicians, because of their specialized training in medicine, are best equipped to treat mental illness.

APPENDIX B

CASE ABSTRACTS

1. I'm thinking of a man--let's call him Frank Jones--who is very suspicious; he doesn't trust anybody, and he's sure that everybody is against him. Sometimes he thinks that people he sees on the street are talking about him or following him around. A couple of times, now, he has beaten up men who didn't even know him. The other night, he began to curse his wife terribly; then he hit her and threatened to kill her because, he said she was working against him, too, just like everybody else.

2. Now here's a young woman in her twenties, let's call her Betty Smith. She has never had a job, and she doesn't seem to want to go out and look for one. She is a very quiet girl, she doesn't talk much to anyone--even her own family--and she acts like she is afraid of people, especially young men of her own age. She won't go out with anyone, and whenever someone comes to visit her family, she stays in her own room until they leave. She just stays by herself and daydreams all the time, and shows no interest in anything or anybody.

3. Here's another kind of man; we can call him George Brown. He has a good job and is doing pretty well at it. Most of the time he gets along all right with people, but he is always very touchy and he always loses his temper quickly if things aren't going his way, or if people find fault with him. He worries a lot about little things, and he seems to be moody and unhappy all the time. Everything is going along all right for him, but he can't sleep nights, brooding about the past, and worrying about things that <u>might</u> go wrong.

4. How about Bill Williams? He never seems to be able to hold a job very long, because he drinks so much. Whenever he has money in his pocket, he goes on a spree; he stays out till all hours drinking, and never seems to care what happens to his wife and children. Sometimes he feels very bad about the way he treats his family; he begs his wife to forgive him and promises to stop drinking, but he always goes off again.

5. Here's a different sort of girl; let's call her Mary White. She seems happy and cheerful; she's pretty, has a good job, and is engaged to marry a nice man. She has loads of friends; everybody likes her, and she's always busy and active. However, she just can't leave the house without going back to see whether she left the gas stove lit or not. And she always goes back again just to make sure she locked the door. And one other thing about her; she's afraid to ride up and down the elevators; she just won't go any place where she'd have to ride in an elevator to get there.

6. Now, I'd like to describe a 12-year-old boy--Bobby Grey. He's bright enough and in good health, and he comes from a comfortable home. But his father and mother have found out that he's been telling lies for a long time now. He's been stealing things from stores, and taking money from his mother's purse, and he has been playing truant, staying away from school whenever he can. His parents are very upset about the way he acts, but he pays no attention to them.

APPENDIX C

SOCIAL DISTANCE SCALE

1. Would you be willing to have a person like this as a neighbor?

2. Would you be willing to have someone like this join a favorite club or organization of yours?

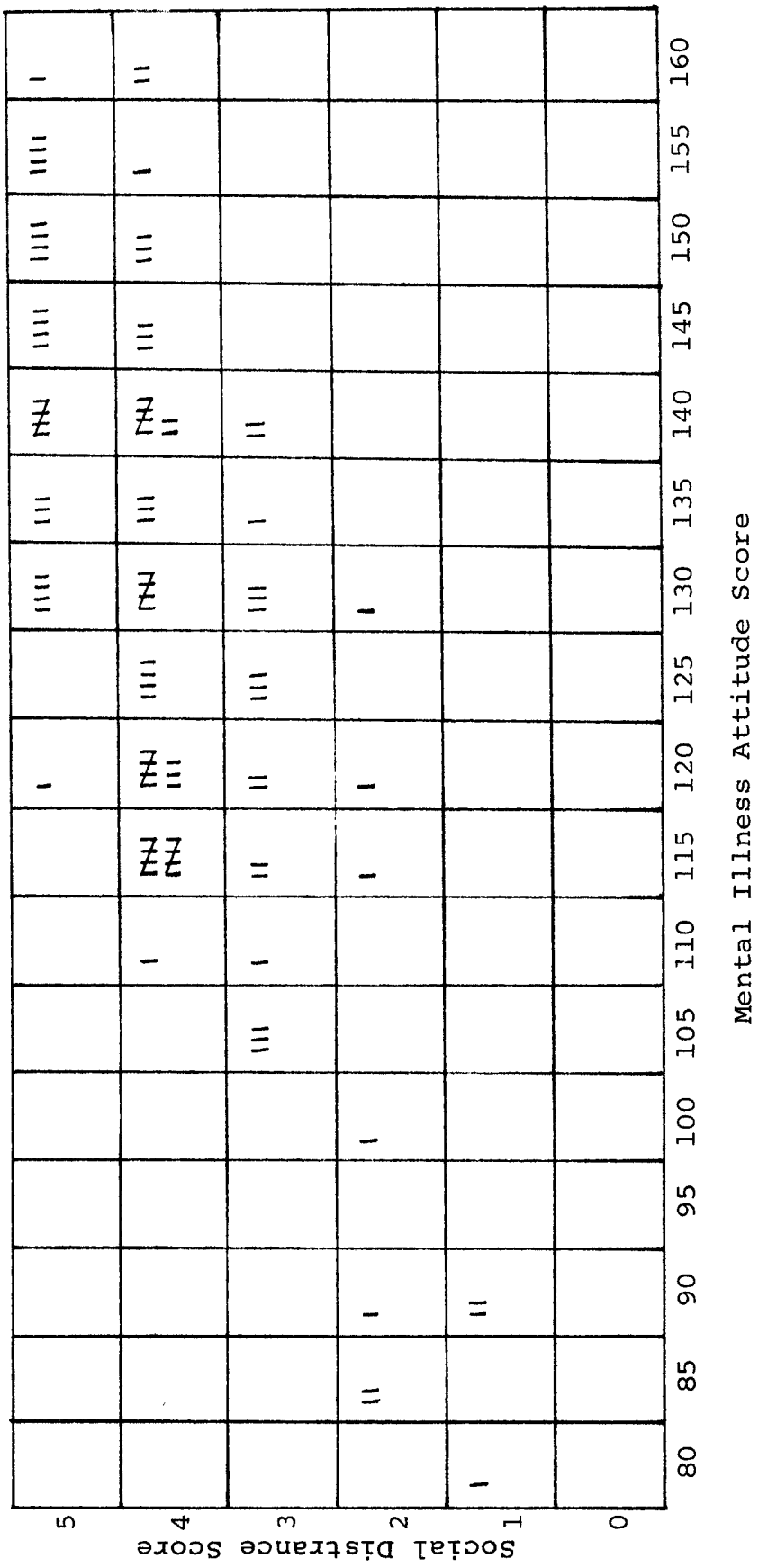
3. Would you be willing to work on a job with someone like this?

4. If you had a room to rent in your home, would you be willing to rent it to someone like this?

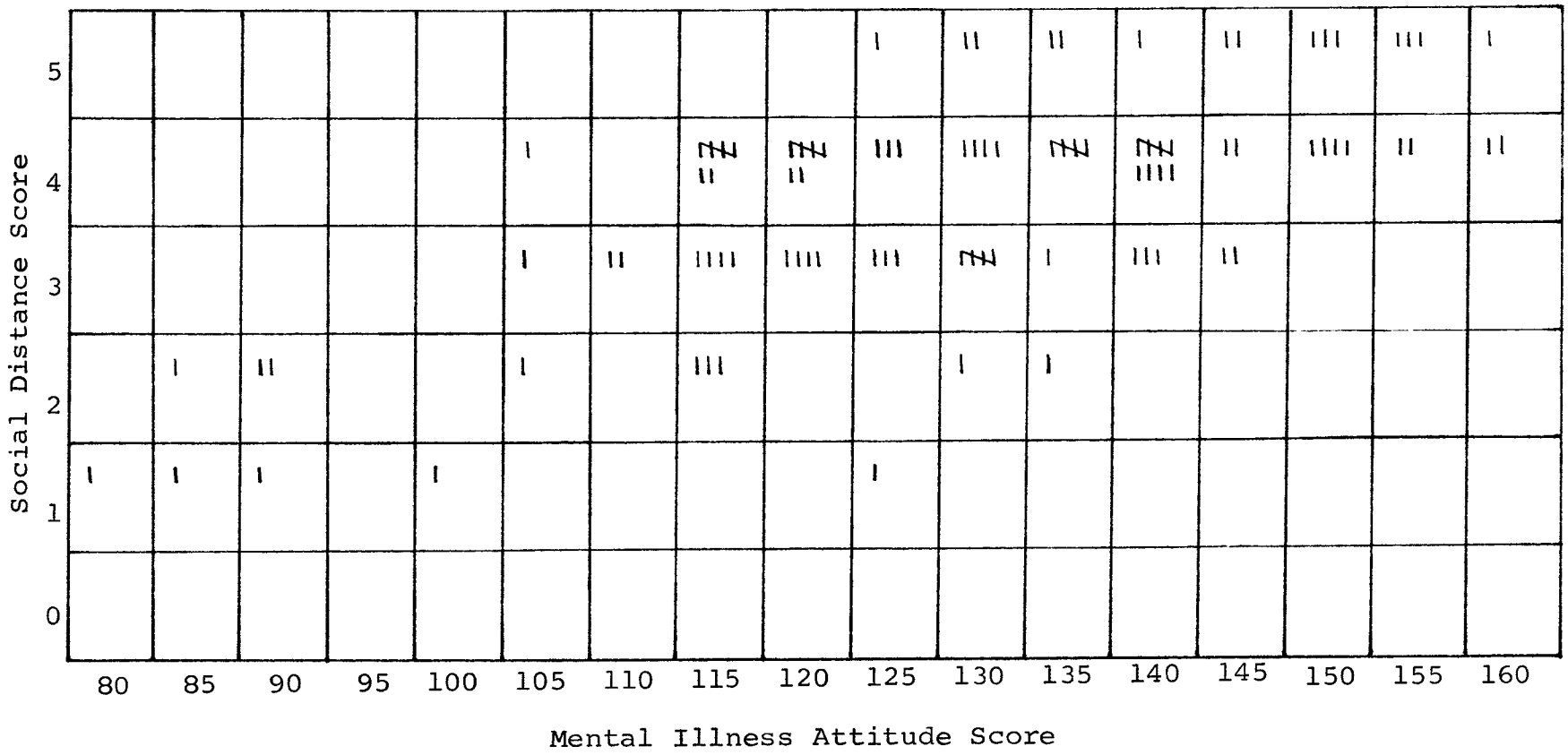
5. Would you discourage your children from marrying someone like this?

APPENDIX D

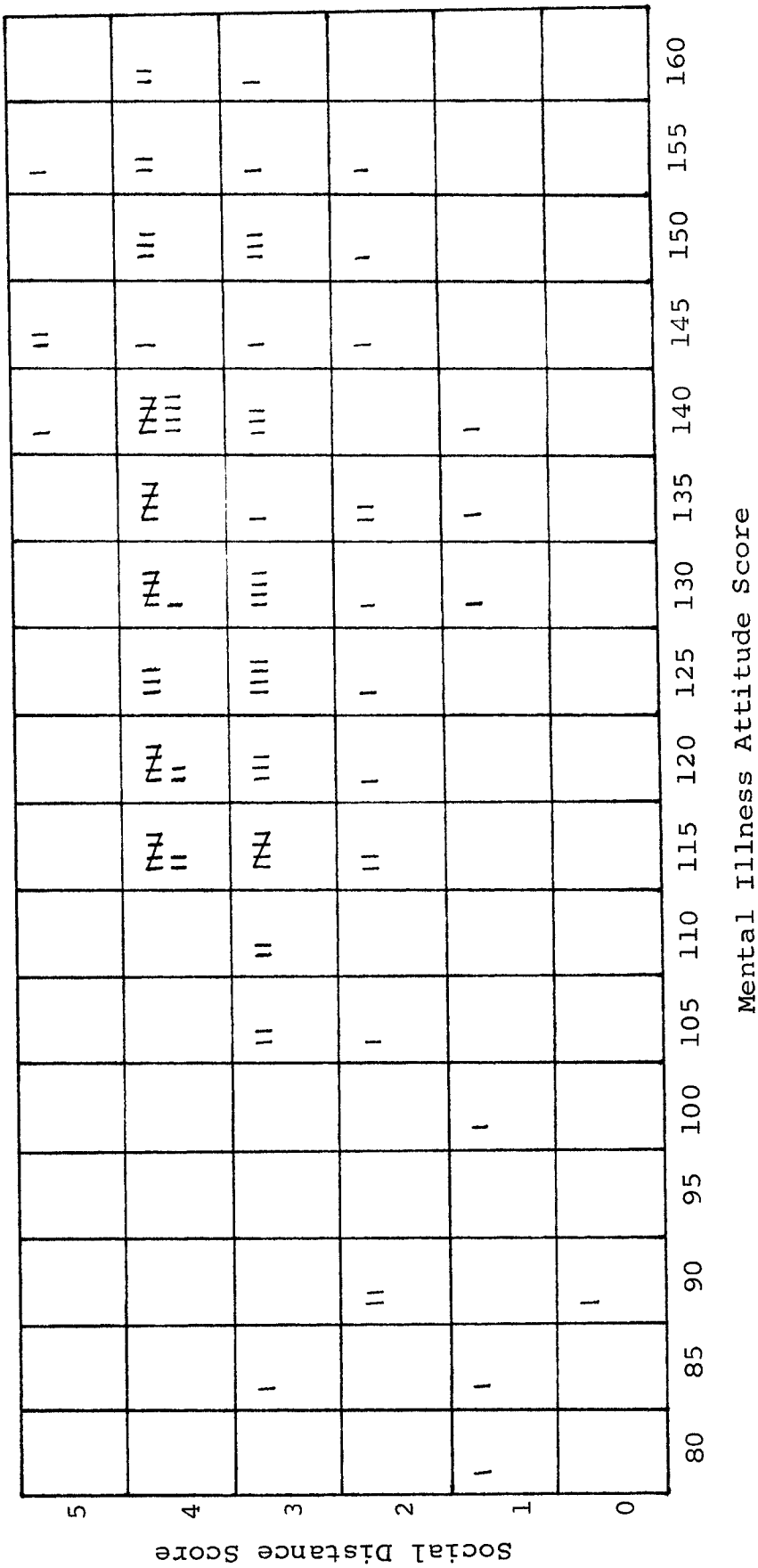
Scattergram of Correlation between AAMIS Score and Social Distance Score for Paranoid Schizophrenic



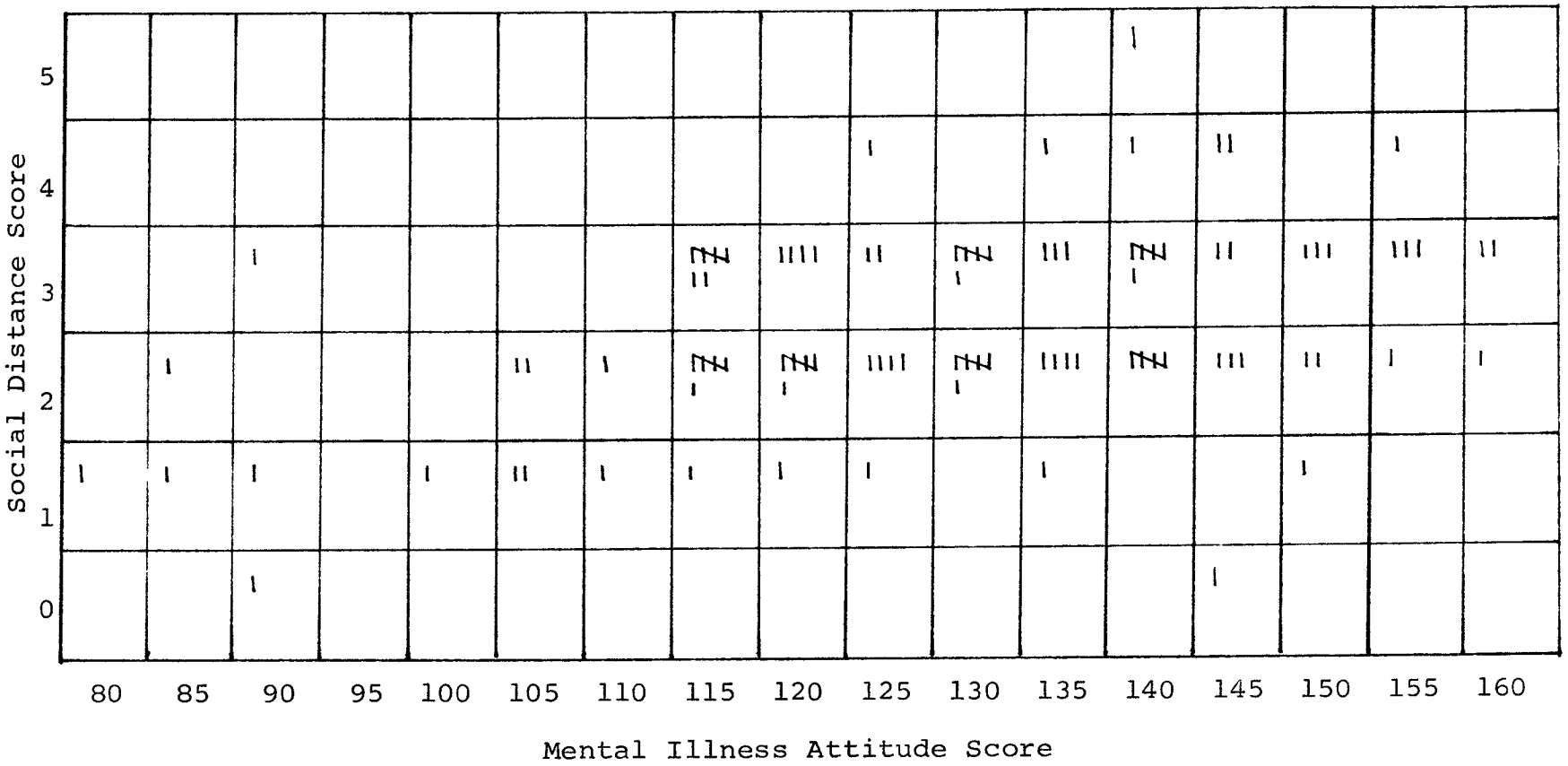
Scattergram of Correlation between AAMIS Score and Social Distance Score for Simple Schizophrenic



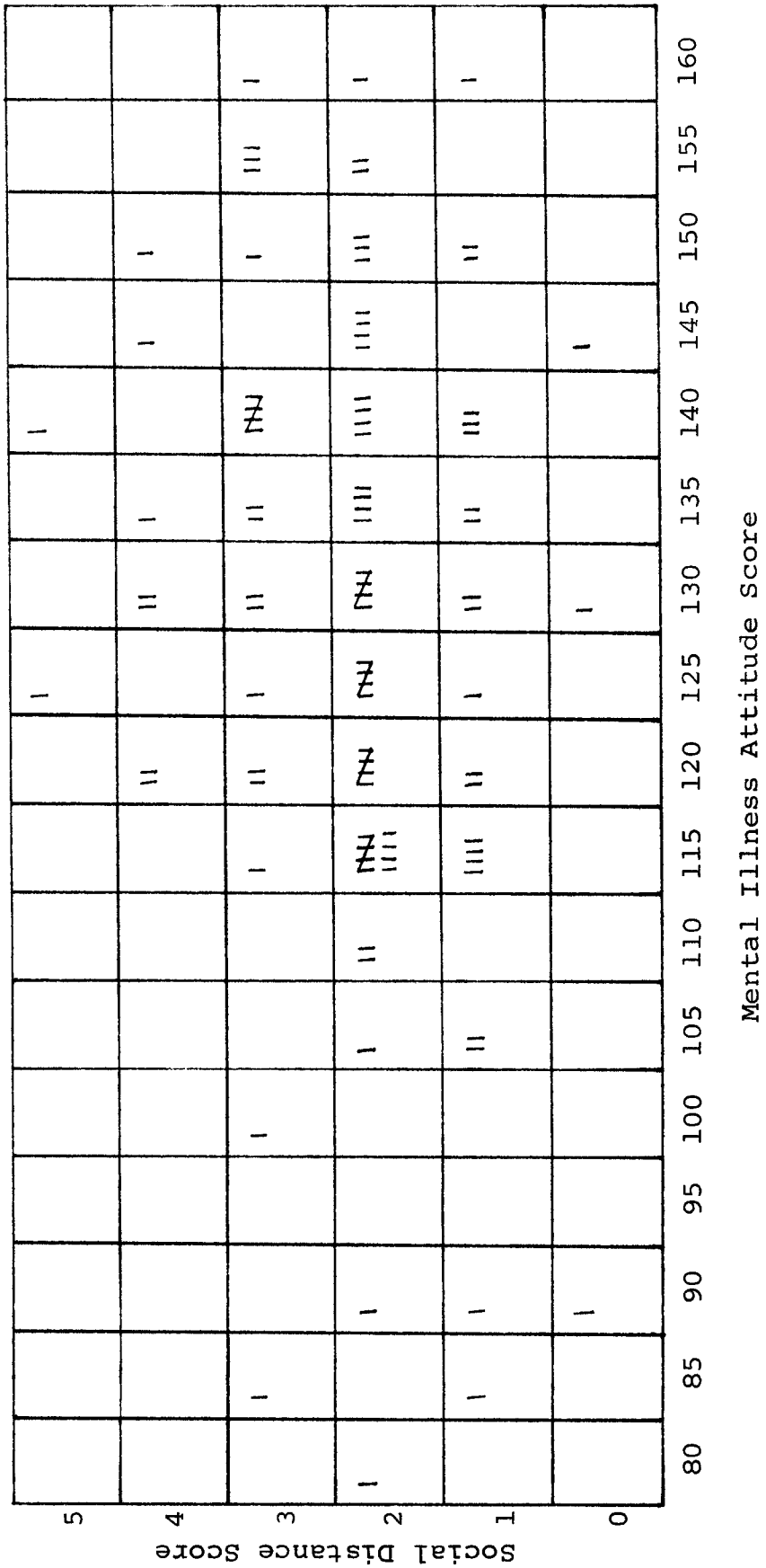
Scattergram of Correlation between AAMIS Score and Social Distance Score for Obsessive Compulsive



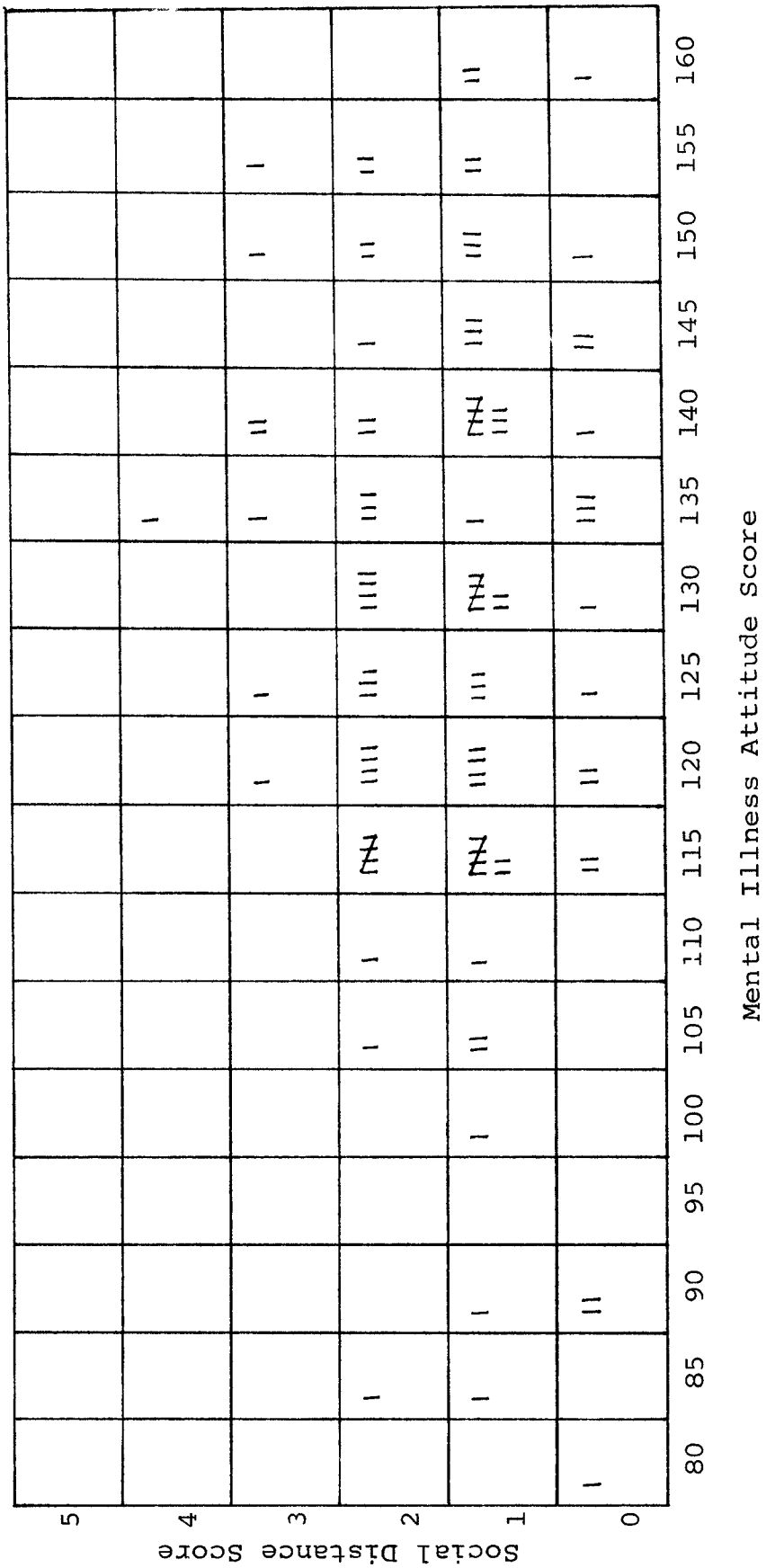
Scattergram of Correlation between AAMIS Score and Social Distance Score for Anxiety Neurotic



Scattergram of Correlation between AAMIS Score and Social Distance Score for Alcoholic



Scattergram of Correlation between AAMIS Score and Social Distance Score for Acting-out Child



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