# TABLE OF CONTENTS

LIST OF TABLES ........................................................................................................... v
ACKNOWLEDGMENTS .................................................................................................. vi
ABSTRACT .................................................................................................................... 1

CHAPTERS
I. INTRODUCTION ........................................................................................................ 2
II. LITERATURE REVIEW ............................................................................................ 5
   A. TELEVISION PORTRAYALS OF THE MENTALLY ILL ....................................... 5
      a. TELEVISION PORTRAYAL STUDIES ................................................................. 6
      b. EFFECT OF PRIMARY INFORMATION SOURCE ON ATTITUDES .................. 8
      c. EFFECT OF TELEVISION GENRE .................................................................. 10
      d. ACCURACY OF PORTRAYALS ...................................................................... 13
      e. POSITIVE PORTRAYALS ............................................................................. 17
   B. COGNITIVE INFLUENCE OF THE MEDIA ......................................................... 20
      a. TRANSPORTATION THEORY ...................................................................... 20
      b. CULTIVATION AND SOCIAL LEARNING THEORY ...................................... 24
      c. SOCIAL IDENTITY THEORY ....................................................................... 25
III. THE PRESENT STUDY ............................................................................................ 30
   A. HYPOTHESES ..................................................................................................... 30
   B. METHODS .......................................................................................................... 31
      a. PARTICIPANTS ............................................................................................... 31
      b. MEASURES .................................................................................................... 32
   C. PROCEDURE ....................................................................................................... 35
   D. RESULTS ............................................................................................................ 36
   E. DISCUSSION ....................................................................................................... 44
      a. ALTERNATE EXPLANATION OF FINDINGS ............................................... 48
      b. LIMITATIONS ................................................................................................ 49
      c. CONCLUSION ................................................................................................. 51
REFERENCES ............................................................................................................... 53
APPENDIX A

1. KENT STATE UNIVERSITY AT STARK INSTITUTIONAL REVIEW BOARD STUDY APPROVAL..........................................................59

APPENDIX B

2. SURVEYS................................................................................................................62
LIST OF TABLES

I. TABLE 1. TABLE OF MEANS AND STANDARD DEVIATIONS ..................37

II. TABLE 2. TABLE OF CORRELATIONS AMONG VARIABLES THAT MEASURE INTOLERANCE .................................................................40

III. TABLE 3. TABLE OF CORRELATIONS AMONG VARIABLES THAT MEASURE TOLERANCE .................................................................42

IV. TABLE 4. GROUP STATISTICS USED IN THE INDEPENDENT SAMPLES T-TEST ....................................................................................43

V. TABLE 5. T-VALUES, P-VALUES, AND DEGREES OF FREEDOM FOR EACH CAMI SUBSCALE .................................................................44
AKNOWLEDGEMENTS

This research paper was made possible through the help and support of my parents, teachers, family, and friends. Especially, please allow me to dedicate my acknowledgment of gratitude toward the following significant advisors and contributors:

First and foremost, I would like to thank my thesis advisor, Dr. James Shepherd, for his support and encouragement. He took time out of his busy day for a year and a half to help me complete this paper, and showed me how to run the analysis of my study. He offered invaluable detailed advice on grammar, organization, and the theme of the paper.

Second, I would like to thank Dr. Leslie Heaphy and Dr. Don Thacker for allowing my surveys to be passed out to their students and taking time out of class to do so.

Finally, I would like to thank my thesis committee: Dr. Lee Fox-Cardamone, Professor Mitch McKenney, and again, Dr. Leslie Heaphy. The product of this research paper would not be possible without all of the aforementioned people.
ABSTRACT

Established research has demonstrated that high television consumption has a negative influence on attitudes about the mentally ill. Television is one of the largest mediums people obtain information about the world, including mental health. Based upon ideas from several theories the present study tested the correlational relationship between television viewing habits, self-esteem levels, and attitudes about the mentally ill. Surveys were passed out to Kent State University at Stark students to assess their self-esteem levels, their attitudes on the mentally ill, and their television viewing habits. The results showed that students watched an average of 9.89 hours of television per week with a range of 0-50 hours. The average score on the self-esteem measure was 30.7, with a range of scores from 14 to 40. Ultimately, the three hypotheses were not supported. Hypothesis 1 produced no significant correlations. Hypothesis 2 showed the opposite of the prediction, and produced numbers that suggest high self-esteem was a better indicator of negative attitudes. For Hypothesis 3, participants were split into groups based on their television watching habits and their scores on the self-esteem measure. Their means were compared using an independent samples t-test, but the t-test did not produce any significant correlations. However, a high percentage of participants had a family member, parent, sibling, or close friend with a diagnosable mental illness, which may have skewed the results. More research is needed to further test the relationship between television and mental illness to reduce stigma.
MEDIA AND MENTAL ILLNESS: THE EFFECT OF TELEVISION ON ATTITUDES ABOUT THE MENTALLY ILL

Malcolm X once said, “The media’s (sic) the most powerful entity on earth. They have the power to make the innocent guilty and to make the guilty innocent, and that's power. Because they control the minds of the masses,” (Haley & Malcolm X, 1987).

Today, television consumption is an everyday occurrence and it takes up the majority of people’s days. It is how we communicate with others, share information, keep up with world events, and entertain ourselves.

Not surprisingly, the statistics on television viewing are staggering. Television is one of the most widely used media sources, according to a study by eMarketer.com, a third-party research company that specializes in media research (“TV, mobile see,” 2011). Nielsen Media Research found the average time a person spent watching regular television per month in 2012 was a total of six days and 54 minutes, and a typical person spent four hours and 11 minutes a day watching TV (Holmes, 2006). Researchers have found there are more people that own a television set than a cell phone. Of the 300 million people in America, 280 million people have at least one television set compared to 234 million cell phone owners (Fox, 2012). These numbers show how often the media has a chance to influence our everyday behaviors and thoughts through controlled presentations of carefully considered information and messages.

Perhaps one of the least inaccurate portrayals by the media is in regards to the mentally ill. Numerous studies have been conducted proving that television has a harmful influence on beliefs and attitudes about the mentally ill. The U.S. President’s
Commission on Mental Health concluded that public beliefs about mental illness are negatively influenced by watching television (Diefenbach & West, 2007). In addition, The National Alliance for the Mentally Ill similarly found that television has a strong, negative influence on public perceptions, which contributes to the stigma surrounding mental illness (Granello, Pauley, & Carmichael, 1999). Frequent depictions of those afflicted with mental illness are often extremely negative, offensive, and completely inaccurate. Often, television shows those afflicted with mental illness as dangerous, violent, mentally disabled, of a low intelligence, lazy, and unproductive members of society (Klin & Lemish, 2008). These troublesome characterizations are readily accessible to all levels and ages of society because of the regular availability of television, films, and newspapers (March, 1999). Easy access to technology allows these incorrect representations to be widespread and common among the general public, making it hard for advocates to counter them. The public’s lack of contact with the mentally ill is significant because it causes them to rely on the media for any information regarding mental illness (Stout, Villegas, & Jennings, 2004).

All mediums of entertainment and news often depict mental illness. Survey information has revealed that the majority of people get information about mental illness from newspapers, television, and magazines (Caputo & Rouner, 2011). Diefenbach (1997) identified that another 51% of people get their information from either family or friends. These results show that very few people get their facts from a reliable source, and that nearly all get it from entertainment media. Consequently, a study done by Pirkis, Blood, Beautrais, Burgess, and Skehan (2006) found that entertainment media has the
strongest and most negative impact on public beliefs about the mentally ill when compared to other mediums. Furthermore, it has been shown that the negative effects of these portrayals cannot be counteracted by presenting non-stigmatizing information about mental illness (March, 1999).

Despite the research, the media does not take responsibility for perpetrating these stereotypes because they are only reflecting the beliefs and values of society. In reality, media is a business. They use mental illness to exaggerate headlines that will gain attention. Their mission is to make news stories that sell (Salter, 2003).

This present study will examine the literature that analyzes the effects of television watching on beliefs about the mentally ill. The study will focus on the content analysis of television that reveal how the mentally ill are portrayed as compared to characters without a mental illness. Results of the study will include how those portrayals affect audience beliefs and attitudes regarding the mentally ill. The accuracy of the portrayals compared to the real world will also be considered. Equally important, psychological concepts that allow the media to have a strong cognitive effect on audiences will be reviewed. Following the literature review, the results of three questionnaires that were distributed to students at a Midwestern university will be evaluated in order to determine if there is a correlational relationship between television watching and attitudes on mental illness. Unlike past studies conducted, this one will be testing for an additional correlation between television watching, mental health attitudes, and self-esteem. Hypotheses on these relationships are to follow the literature review.
LITERATURE REVIEW

Television Portrayals of the Mentally Ill

The first studies conducted on the influence of television on tolerance toward the mentally ill did not occur until the 1950s. Since then, it has been widely established that mental illness portrayals on television are unreasonably false, and that the public uses the media as its primary source of information about mental health. Reviews of the literature reveal a tendency for television shows to negatively portray the mentally ill as criminals, dangerous, childlike, violent, unpredictable, absent of any moral or social restraint, unproductive members of society, and incapable of holding a job (e.g. Diefenbach, 1997; Diefenbach & West, 2007; Hoffner & Cohen, 2012; Klin & Lemish, 2008; Nairn, 2007; Salter, 2003; Sieff, 2003). They also use biased and stimulating language to narrowly define anyone with a mental illness.

All media outlets use mental illness to embellish stories and create thrilling plotlines, but survey research shows that television is one of the main sources cited regarding mental illness knowledge. Surveys by Daniel Yanklovich Group, Inc. (1990) report 87% of people use television and television news programs as their primary source of mental health information. Television also has a socializing effect, influencing people to judge what is being shown on screen to be a reflection of reality (Stout et al., 2004). Television dramas reach more of the population than any other programming. These shows that are depicting “ordinary” life provide a situational framework to the general public in which they form an understanding of mental illness and how to act toward those afflicted (Salter, 2003). Further research concludes that television watching and attitudes
about the mentally ill have a negative correlation: as television watching goes up, the less tolerant one is of the mentally ill.

Philo et al. (1994) described people as being active consumers of information, meaning they continuously are adding information to their current mental health schemas as they watch television. Any significance that they assign to new information depends on their current knowledge, and it has been proved that people automatically arrange information according to common stereotypes. Salter (2003) concludes that the media uses common misperceptions already held by the public to create and sell stories, which only reaffirms their established beliefs. Moreover, classifications of characters are often extremely vague and provide no mention of a specific diagnosis, causing broad generalizations to further add to the incorrect knowledge of the viewer (Hoffner & Cohen, 2012).

**Television Portrayal Studies.** Numerous studies have been done to examine how the mentally ill are portrayed on television and how often. Sieff (2003) concluded that television programs first define a mentally ill character by their mental illness. Only after do they characterize them by their individuality. A Washington, DC study discovered one out of eleven television shows and 33% of prime-time television shows illustrated some aspect of mental illness (March, 1999). Rose (1998) discerned that the mentally ill were shown as violent towards others in 65% of news programs within a three-month period. Goldstein (1979) looked at police and crime dramas and discovered negative labels were attributed more to mentally ill offenders than to other types of offenders. Mentally ill criminals were also presented as more dangerous than other offenders.
Signorelli (1989) found that mentally ill characters were more likely to be presented as “bad”. As part of the Cultural Indicators Project, Signorelli examined samples collected from 17 weeks of prime-time television between 1969 and 1985. Results reported that 72.1% of mentally ill characters either hurt or killed others, and 75.7% were victims of violence. Only 2.7% of the mentally ill were shown in a comical role while 83.5% were shown in a serious role. Wahl and Roth (1982) looked at prime time television and concluded both entertainment and news media often portray mental illness negatively.

Fruth and Padderud (1985) determined that daytime serials provide stereotypical and off-putting images of mental illness. Every 6 out of 8 mentally ill characters on daytime soap operas were shown engaging in criminal activity. Their study also showed that appearance and behavior of mentally ill characters differed greatly from others. Additionally, Fruth and Padderud concluded that 33% of all mental illness depictions indicated that the mental illness was a severe and grave disease. Diefenbach (1997) found that mentally ill characters are portrayed as ten times more violent than other characters. Hoffner and Cohen (2012) determined that the mentally ill are rarely shown as being a valuable, productive member of society.

Last, March (1998) analyzed over 50 television programs throughout a two week period. He found that out of all the characters shown committing a violent act, 72.1% of them that were depicted as mentally ill and they hurt or killed others. As well, 8.7% of main adult characters were murderers, although 21.6% of them were portrayed as mentally ill. Further, 66% of the mentally ill characters held jobs, but half of them were
depicted as failures, compared to 15% of normal characters that were shown as failures. Overwhelmingly, television programs portray mentally ill characters decidedly more negatively and violently than normal characters.

**Effect of primary information source on attitudes.** Information sources can have a profound effect on mental illness attitudes. Granello et al. (1999) studied 102 undergraduate students at a Midwestern university to determine if there were differences between attitudes based on primary sources of information. After three students left items missing on several survey questions, the total sample was reduced to 99. Students were asked to complete The Community Attitudes on the Mentally Ill (CAMI) scale before filling out a demographics survey.

The CAMI was administered to measure thoughts and beliefs about the mentally ill while the demographic survey revealed their primary source of information. Different primary sources in this study were print media, electronic media, family or friends with a diagnosable mental illness, work experience with the mentally ill, and school work. According to the study, electronic media included television, films, and videos. Participants were asked to respond to statements like "The mentally ill are a burden on society" and “No one has the right to exclude the mentally ill from their neighborhoods”. Five answer choices ranged from strongly disagree to strongly agree, with half of the items needing to be reverse scored. Within the CAMI, there are four subscales: Authoritarianism, Benevolence, Community Mental Health Ideology, and Social Restrictiveness.
Within each subscale, the higher the score means greater agreement. Tolerant people would consequently be expected to score higher on the Benevolence and Community Mental Health Ideology scales while an intolerant person would be expected to score higher on the Authoritarianism and Social Restrictiveness scales. The Authoritarianism subscale measures views of superiority over the mentally ill. Those who score high in this subscale believe in the need to hospitalize all of those afflicted with a mental illness. The Benevolence subscale measures views on society’s responsibility for taking care of the mentally ill. High scores on this subscale mean one thinks society should be kind and sympathetic to the mentally ill. Social Restrictiveness calculates the degree to which one feels threatened by the mentally ill, and high scores in this subscale indicate a willingness to distance themselves from them. Last, the Community Mental Health Ideology assesses beliefs in community-based healthcare opposed to hospitalization in institutions. Those in agreement with this subscale put a greater therapeutic value on society and promote the deinstitutionalization of mental hospitals.

Results showed that the primary source of information had the most noteworthy impact on attitudes, as compared to other demographic factors studied like race, year in school, gender, and hometown population. Of all the primary information source groups, the electronic media group was the most intolerant whereas those who chose to work directly with the mentally ill were the most tolerant. Schoolwork and taking courses on mental illness also predicted a more open-minded view. Those who received their knowledge of mental illness from electronic media sources scored higher on the Social Restrictiveness and Authoritarian subscales and lower on the Community Mental Health
Ideology subscale compared to other subjects who reported other primary sources of information. Those who stated print media was their key source demonstrated higher acceptance of the mentally ill when compared to the electronic media group. They scored in a more tolerant direction on all subscales, and most significantly on the Community Mental Health Ideology subscale.

Contrary to the researchers’ hypotheses, the group who obtained mental illness knowledge by having contact with a family member or friend with a mental illness also demonstrated less tolerance and were more closely aligned with the electronic media group. In fact, the electronic media group and the mentally ill family member or friend group were almost completely aligned on all the subscales, demonstrating the least amount of tolerance. Overall, however, those who learned about mental illness from the electronic media were the most prejudiced, demonstrating the remarkable effects of primary information source on attitudes about the mentally ill.

**Effect of television genre.** Further research by Granello & Pauley (2000) specifically looked at how the amount of television and the type of program affects attitudes of college students. Questionnaires designed to determine the primary source of information about mental illness were handed out to 183 undergraduate students. Of the total number of students who took the survey, 154 completed the measure correctly and 53 subjects reported television as their primary source of information. The analysis only included those that received information from television and excluded others that reported other sources.
To measure attitudes towards the mentally ill, participants were administered the CAMI during a regularly scheduled class. Furthermore, a questionnaire was also handed out to determine the amount of hours the students watched television week and the types of shows. Answer choices included 0-5 hours, 6-10 hours, 11-20 hours, 21-30 hours, and 31 and over hours per week. Results showed that the group watched between 11 and 20 hours a week on average. The most popular programs viewed were sitcoms at 0 to 15 hours per week, music television at 0 to 20 hours per week, daytime soap operas at 0 to 12 hours a week, television movies at 0 to 16 a week, sports at 0-11 hours a week, and news at 0 to 12 hours a week.

The results of a trend analysis showed a positive relationship between watching more television, scoring higher on the Authoritarianism subscale, and scoring lower on the Benevolence and Community Mental Health Ideology subscales. Participants who reported watching less than 5 hours per week scored the lowest on the Authoritarianism subscale and highest on the subscales of Benevolence and Community Mental Health. As the number of hours in each category got lower, the scores on Benevolence and Community Mental Health subscales got correspondingly higher. On the other hand, with each increasing category of television watched per week, the scores on the Authoritarianism subscale were higher. It was discovered that watching television had no effect on the Social Restrictiveness scale.

Nonetheless, Granello & Pauley concluded that the more one watches television, the less tolerant they will be less tolerant toward the mentally ill. Nielsen Media Research (1998) states that the national average of television watched for college aged students is
20 to 24 hours a week. In this sample, the average was between 11 and 20 hours, which implies that even a small amount of television can affect attitudes about the mentally ill. This also confirms the research that says mental illness portrayals on television are inaccurate and promote stigma.

The types of television programs watched had an additional effect on mental illness attitudes. Using a multiple regression analysis, the relationship between scores on the CAMI subscales and type of program watched was found. Between 10-23% of variance on the CAMI subscales was due to how much time was spent watching a specific type of program. Daytime soap operas accounted for the most variability within the Authoritarianism subscale, followed by sitcoms, and then a combination of both sitcoms and soap operas at 23%. There was a positive correlation between watching soap operas and sitcoms with scoring high on the Authoritarianism subscale. As watching soap operas and sitcoms went up, the scores on this subscale also went up. Within the Benevolence subscale, sitcoms accounted for 11% of the variability, followed by sports, and then a combination of sports and sitcoms at 18%. A negative correlation was found between watching sitcoms and sports with the Benevolence subscale. As watching sitcoms and sports went up, scores within the Benevolence subscale went down. Watching sports was the only variability factor within the Community Mental Health Ideology subscale, and watching sports negatively correlated with scores in that subscale. Watching sports correlated with lower Community Mental Health Ideology subscale scores. Last, the only factor that accounted for variability within the Social Restrictiveness subscale was watching news. There was a negative correlation between
watching news and scores on the Social Restrictiveness subscale. Surprisingly, as news watching went up, the lower the scores on the Social Restrictiveness subscale. Overall, three subscales were affected by the types of television watched and each showed a less tolerant view: Authoritarianism, Social Restrictiveness, and Community Health Ideology.

*Accuracy of portrayals.* Today, people perceive the mentally ill to be more dangerous than what was believed 50 years ago (Sieff, 2003). As time passes, the stigma attached to mental illness increases as progressively more people view the mentally ill as violent. Estimations of violence committed by the mentally ill are extremely overestimated by the general public due to repeated news exposure. Reporting of a crime numerous times on multiple media outlets like television news, radio, and internet, gives the impression that the mentally ill are habitually violent. Every time the same crime is reported on a different media source, the stereotype that the mentally ill are unpredictable and dangerous is strengthened. It is even said that society would feel less safe to hear someone was murdered by a mentally ill person as opposed to hearing someone was killed in an armed robbery (Stuart, 2006).

Contrary to popular beliefs, major studies specify that the majority of prisoners do not have a mental illness, and the majority of the mentally ill will never be incarcerated. Only 6-15% of the total prison population meets the criteria for a mental illness laid out in the *Diagnostic and Statistical Manual of Mental Disorders*, which is the standard manual used for determining mental illness diagnosis in the United States (Granello et al., 1999). Cocozza et al. (1978) found that the demographic profiles of incarcerated mentally ill matched the demographic profiles of future arrests made in the general
population, suggesting that mental illness is not a prime factor in committing crimes. The evidence suggests that socioeconomic status and prior arrest history is a greater predictor of violence. Research has also determined that former hospitalization was not a future predictor of arrests. Shows and news programming, however, do not make it apparent in their depictions and portrayals of the mentally ill that a small minority with mental illness commit crimes (Klin & Lemish, 2008).

Diefenbach (1997) conducted an experiment that looked to compare rates of violence committed by mentally ill characters and non-mentally ill characters on television. The study used the highest estimates of violent mentally ill criminals reported by Cocozza et al. (1978) in order make it harder to support the hypotheses. Diefenbach evaluated 2-week’s worth of violent crime on television and 52-week’s worth of violent crime in the real world. September was randomly chosen because it offers a broad expanse of television shows: reruns, new fall shows, and fall specials. Each of the 184 programs were recorded between 8PM and 11PM twice within the two weeks, resulting in 167 hours of television. ABC, CBS, FOX, and NBC comprised of 71% of the prime-time television that was recorded during the time period.

Four hypotheses were tested. Hypothesis one said that mentally ill characters on television would be portrayed as more violent than the mentally ill in the real world. Hypothesis two supposed that mentally ill characters would be shown as more violent than other characters on television. Hypothesis three stated mentally ill characters will have a lesser quality of life compared to others. Last, hypothesis four theorized mentally ill characters will be shown as negatively impacting society compared to others.
Four coders were recruited to view the blocks of television programming. They were trained in identifying violent crimes according to definitions provided by the United States Department of Justice and taught how to classify mental disorders according to the American Psychiatric Association. In order to ensure reliability, 10% of the samples were checked by multiple coders. Also, the coders were instructed to make two global assessments for each mentally ill, violent, or crime victim character: overall quality of life and overall impact on society. A five-point Likert scale was utilized in making judgments, ranging from 1 (very negative) to 5 (very positive).

The results included 127 of 4,362 characters classified as mentally ill, with 96 of them having speaking roles. Of the 187 programs, 58 of them contained at least one mentally ill character. In total, 33.9% were shown committing murder, robbery, rape, or assault. When voluntary manslaughter, abuse, kidnapping, unlawful imprisonment, reckless endangerment, extortion, and intimidation were added, the number of overall violent mentally ill characters rose to 44.1%. The coders identified psychosis as being the most commonly portrayed mental illness in prime-time television sample.

Genre of the television program did not have an effect on how the mentally ill were portrayed. In situation comedies, there were no dangerous mentally ill characters identified. However, crime dramas, reality-based shows, news magazines and movies were the top offenders, portraying the mentally ill as violent over 50% of the time. The average rate of portraying the mentally ill as violent across all other genres was 11.8%. The offender rate of the mentally ill characters was nearly ten times higher than the offender rate of the normal characters. The quality of life that a mentally ill character had
was shown to negatively affect society and suggested that their life’s value was lesser than a dangerous criminal.

A gender bias was found to favor females. Only 24.4% of the mentally ill female characters were shown as violent compared to 70.1% of the male characters. The other 5.5% had a gender that could not be determined. Surprisingly, these rates are very close to the real world statistics. Men commit 87.5% of violent crimes while women commit 12.5% of them. It was also observed that mentally ill characters were rarely portrayed as a victim of a crime and are four times as likely to be represented as a criminal. However, in the real world, mentally ill people are more likely to be a victim of a crime than perpetrate one. Diefenbach (1997) concluded that mentally ill characters are depicted as more violent than other characters and tremendously more violent than the mentally ill in the real world.

In a more recent study on the accuracy of portrayals, Diefenbach and West (2007) did an updated content analysis of prime-time television to determine how today’s media depicts mental illness. They modeled the study after Diefenbach’s (1997) study. Roughly 84 hours of programming were analyzed, covering a week’s worth of prime-time television. The sample again included shows from the ABC, CBS, Fox, and NBC networks that aired between 8 PM and 11 PM. Raters studied the sample and identified characters with a mental illness defined by the DSM-IV. Coders were twelve undergraduate seniors majoring in mass communication and were trained to identify behaviors and labels that characterize mental illness. They were told to use a “reasonable viewer” standard when coding in order to objectively cover everything that a rational
viewer would view as a mental illness. As in the previous study, raters were instructed in the identification of violent crimes according to the US Department of Justice, which included murder, rape, robbery, aggravated assault, manslaughter, abuse, kidnapping, endangerment, and intimidation. Two global assessments were made using a 5-point Likert scale: quality of the character’s life and their impact on society.

It was found that 29 characters were classified as mentally ill. Alcohol abuse was the most common portrayal at 31%, then drug addiction at 14%, schizophrenia and psychosis at 14%, personality disorder at 14%, and mood disorder at 10%. Out of these, 11 characters were shown committing violent criminal acts which is an offender rate of 37%. There were 38 violent crimes committed by these 11 characters: 13 murders, 11 rapes, 2 robberies, 2 aggravated assaults, 9 cases of abuse, and 1 case of reckless endangerment. This averages out to 3 violent acts per person.

Statistically, the collected data shows that the offender rate of the mentally ill on television is nine times higher than in the real world, which is roughly 3.5%. There were 2,027 non-mentally ill characters in the sample and 93 of them were violent criminals, producing an offender rate of 3%. On television, mentally ill characters are ten times more likely to commit a violent crime than a non-mentally ill character. The quality of life global assessment was averaged at 2.48, and the effect on society global assessment average was 3.0, both lower than the average of non-mentally ill characters.

**Positive portrayals.** Hoffner and Cohen (2012) looked at the USA television series Monk, which aired from 2002-2009, to examine the effects of a positive portrayal of mental illness on television. The show’s main character, Monk, is a detective with
Obsessive Compulsive Disorder (OCD), an anxiety disorder characterized by excessive thoughts and behaviors that lead to abnormal fears and daily habits. Monk uses his OCD to meticulously and thoroughly look over every detail of complex crimes in order to solve them. His disorder is presented in a light, comical manner. He relies on his personal assistant to help him because of his OCD and other various phobias. This series was chosen because of its success and wide popularity. It has won multiple awards for its depiction of OCD and how that has reduced mental illness stigma. After airing for eight seasons, the series finale of Monk was the most watched episode of any drama series on cable.

The study examined how fans of the show reacted to Monk, how it influenced their views of mental illness, and why they watched the show. Fans are more likely to relate to the characters as opposed to casual viewers, and fans with OCD should display a strong connection with Monk. The subjects of the study were Monk fans with OCD, and Hoffner and Cohen (2012) used parasocial involvement and the influence of presumed influence model to measure attitudes about mental illness. A parasocial relationship forms between an audience member and a media character, and in this case their personal experience influences their understandings of mental illness that is shown on Monk. The parasocial relationship allows viewers to connect to Monk and increase their own sense of value, especially those who have a mental illness.

For those viewers who did not have a mental illness, the optimistic portrayal created a view that these positive features are normal among the mentally ill. The media has a normative influence on society, making certain ideas and concepts the standard.
Currently, the standard of viewing the mentally ill is negative. Due to the representation of mental illness through Monk, the portrayal could disprove some common beliefs that the mentally ill are dangerous, unintelligent, and are a detriment to society. Thus, a parasocial relationship with a character with a mental illness could potentially decrease the stigma and fear surrounding the mentally ill.

A survey was posted on the SurveyMonkey website and the hyperlink was posted on eight Monk message boards, including Yahoo, Google, and USA Network, inviting fans to participate. The survey was open between September 10 and September 30, 2008, allowing participants to take the survey before and after the seventh season finale of Monk, which aired the third week in September. Among the 142 respondents, all of them were devoted fans of Monk and watched it regularly. Results showed that 88.7% had viewed the entire series at least once, and 48.6% reported owning at least one set of Monk series DVDs. Also, 32 indicated having OCD and another 33 had another mental illness other than OCD, making 45.8% of survey takers personally involved with a mental illness. As well, 26 reported having a family member with OCD.

Results showed a strong parasocial relationship with Monk decreased stereotypical beliefs and increased willingness to be around those with a mental illness. For the viewers who had personal experience with mental illness, they reported a greater enthusiasm to seek out treatment because of watching Monk. In addition, the show had psychological benefits for those with OCD because it helped them positively increase their self-view. Although this study does not imply causation, Hoffner and Cohen (2012)
believe that having a close relationship with a fictional character could change beliefs, attitudes, and behaviors.

In summary, watching television has been shown to negatively affect attitudes on the mentally ill because of the misrepresentations and portrayals by the media. The most common portrayal is that the mentally ill are dangerous and unpredictable. However, this is highly inaccurate. While a very small percentage of mentally ill do commit crimes, the overwhelming majority are harmless to others. Some of the more positive portrayals seen on television may help in regards to people’s attitudes, but those who watch television have been proven to hold more negative views and stereotypes about the mentally ill.

**Cognitive Influence of the Media**

Stout et al. (2004) posit that heavy exposure to television can act as a socializing agent, which contributes to the stigmatization and mistaken beliefs about the mentally ill. In the case of television, constant experience and interaction misconstrues perceptions about crime, law enforcement, and personal characteristics about the mentally ill in general. Most of what people think about the world comes from the media. There are four mass communication and social psychology theories that support this: transportation theory, cultivation theory, social learning theory, and social identity theory.

*Transportation theory.* Caputo and Rouner (2011) describe transportation as the extent to which one is cognitively and psychologically invested in reading a book, watching a film, or involved in any means of mass communication. Generally, however, it is more likely that transportation will occur with entertainment media, including television. According to the social-cognitive model, entertainment media has the capacity
to send the public messages about the mentally ill through their portrayals, which can foster discrimination and stigmatization. Transportation is an explicit mental process that involves an integrative combination of imagery, attention, feelings, and a focus on events. These mental processes are what allow an individual to be immersed and absorbed into the story, whether the account is fiction or non-fiction. Since media plays a pivotal role in people’s lives and how they perceive the world, it is important to look at how being in a transported state can change one’s attitudes and beliefs.

Depending on how involved an individual is with the story, there are individual differences in how one processes media messages. When one is transported into a story, it leaves the individual susceptible to attitudes and beliefs presented because it weakens their ability to challenge them. Being in a transported state causes one to become lost in the story. They put aside common sense and as they become more engaged, they lose their ability to critically analyze anything presented in the narrative. Individuals seemingly forget their real surroundings but not to the point that they overlook previous experience or one’s own personal life. Being in a transported state in response to certain parts of the story can cause one to change their attitudes about the real world, including their views about the mentally ill. In past studies, audience members have been found to accept false statements about mental illness presented in various fictional narratives, like “mental illness is contagious”.

There are various key parts of the transportation process. A consideration when looking at the mental processes of individuals is the perceived realism of mental illness portrayals. The more one views the media representations as real, the more likely their
attitudes, beliefs, and behaviors will change. Researchers call the element of perceived realism the “magic window,” which is the level the individual believes television representations are accurate.

Second, identification is another aspect that affects the transportation of an individual. Identification is the degree the viewer recognizes a character as being similar to them or to a person that they would have a relationship with in their own life. If an individual is fully transported and has a strong identification with a character, they will be influenced about real-world issues presented in the story. A strong identification decreases the awareness of self in an individual and opens them up to different perceptions and opinions. Again, having a “shared identity” with a character makes one more vulnerable to persuasion and can replace current beliefs with other ones. On the other hand, if the viewer secretly identifies with a character but does not want to confront the truth that they are similar to them, then it is less likely they will be transported in the story.

Caputo and Rouner’s (2011) study tested the relationship between transportation and perceived attitudes about the mentally ill. The perceived attitudes were determined by measuring social distancing behavior in the participants. Social distancing distinguishes social and intimate relationships, and in this study the willingness to interact with the mentally ill was considered. It has been found in past research that an increased perception of dangerousness is a common factor in social distancing behavior. Negative attitudes about the mentally ill can cause fear and avoidance which lead to social distancing. Familiarity or experience with mental illness has also been found to
decrease social distancing behavior and stigmatizing attitudes. It was hypothesized that increased familiarity, transportation, and perceived realism would show less social distancing behavior.

The study took place at a Western university where 137 students watched a television version of *Prozac Nation*, a film based off a true story that depicts depression. None of the participants had seen or read *Prozac Nation*. Before the participants watched the television movie, they were told it was either fiction or non-fiction.

Approximately 48.1% of the participants were in the fiction group while 59.1% were in the non-fiction group. After the movie ended, a series of questionnaires were handed out to the participants that measured transportation, familiarity, character identification, perceived realism, and social distancing behavior. All questions were based off an 11-point Likert Scale. There were two dimensions of transportation that were measured: story involvement and story relevance. Questions regarding story involvement evaluated how immersed the viewer was in the story, using statements like, “I found myself thinking of ways the movie could have turned out differently”. Story relevance calculated the degree to which the viewer thought the characters and plot related to their own lives, using statements like, “The events in the movie are relevant to my everyday life”.

Results showed that 90% of the viewers received information about the mentally ill through films. Also, 95% of the participants noted that they were aware of the genre of the film as they watched. In regards to familiarity, only 64% of the participants reported no past experience with mental illness. A univariate analysis showed the relationship
between familiarity and genre had no effect on social distancing behavior. However, the outcomes showed greater social distancing behavior toward the mentally ill the more one was transported into the film.

*Cultivation and social learning theory.* Similar to transportation theory, cultivation theory states that regular exposure to media messages will socialize and shape one’s view of reality to be similar with what is being presented (Stout et al., 2004). The media will “cultivate” certain ideas and messages through their representations which can eventually take root and be perceived as reality. Gerbner, Gross, Morgan, Signorelli, and Shanahan (2002) sum up the theory nicely: “Those who spend more time 'living' in the world of television are more likely to see the 'real world' in terms of the images, values, portrayals, and ideologies that emerge through the lens of television,” (p. 47).

This works simultaneously with social learning theory, which says that learning can be achieved through direct experience and observation (Bandura, 1986). Social constructionists believe that one assigns meaning to what is seen or heard on television. Those meanings that are created are important in what individuals constitute as reality (Granello et al., 1999). The more meaning assigned, the more likely it is perceived as reality. Over time, those meanings start to form an “image bank” that holds what one believes to be true. In the case of mental illness, most people’s “image banks” hold violent or dangerous views because those are the most familiar representations that are presented by the media (Nairn, 2007).

As one watches television, they additionally learn behaviors and social conventions that are supposedly acceptable even if they have not personally performed
them in the past. The nature of the portrayal can have a major effect on whether that behavior will be repeated in real life or not. Observing behaviors on television that have been rewarded significantly increases the likelihood that they will be implemented in the real world and vice versa with behaviors that are punished. This can be applied to the stigma surrounding mental illness because, according to social learning theory and cultivation theory, television teaches people how to act toward the mentally ill (Stout et al., 2004). When one does not have experience with mental illness, they learn how to interact with the mentally ill by what they see on television—social learning theory—and when they repeatedly see the same behavior towards the mentally ill, they believe that it is socially acceptable behavior—cultivation theory.

**Social identity theory.** Social identity theory states that one defines their own social identity based on what collective groups they belong to (Hoffner & Cohen, 2012). Different factors could determine one’s membership: personal characteristics, status, or shared experiences. For example, race, age, gender, and political party are potential variables that one considers when deciding their social identity and what groups they belong to. Having a defined social identity allows individuals to engage in intergroup comparisons, which can have psychological benefits. Group membership increases one’s sense of belonging and raises self-esteem. Meindle and Lerner (1984) suggest that group membership can also be a remedy for low self-esteem, since it enables the individual to engage in intergroup comparisons. Logically, individuals want to enhance their own group’s status, and they favor their own group over others, which also increases self-esteem. If the individual can view their own group more positively compared to another
group, or if the other group can be viewed as more negative than one’s own group, self-esteem increases. As part of the social identity theory, Abrams and Hogg (1988) proposed the self-esteem hypothesis, which has two parts: (1) inner-group discrimination increases self-esteem and (2) threatened or low self-esteem increases out-group discrimination. For example, an instance of inner-group discrimination could be degrading another teammate to feel even better about one’s own skills, and an example of out-group derogation could be insulting the opposing team when they win against your team to feel better.

These theories address the social psychology construct of “us” versus “them.” As a way to self-enhance, individuals show discrimination against other groups and favor their own (Abrams & Hogg, 1988). According to psychoanalytic theory, people with low self-esteem project their own pessimistic and negative views onto outgroups, resulting in discrimination and prejudice. Despite this view, it is hypothesized that ingroup favoritism is more common than outgroup derogation when trying to increase self-esteem; however, outgroup derogation may be useful as a defense mechanism when there is a threat to the group’s identity (Branscombe & Wann, 1994).

Research findings testing both corollaries of the self-esteem hypothesis are mixed. There have been few studies that have tested the self-esteem hypothesis in real intergroup contexts (Houston & Andreopoulou, 2003). Out of all the studies, 9 out of 12 supported Corollary 1, while only 3 out of 19 supported Corollary 2 (Rubin & Hewstone, 1998). Turner (1999) dismisses these findings as a failure to properly measure self-esteem. Farnham, Greenwald and Banaji (1999) also agree that the findings may not accurately
reflect true self-esteem processes in intergroup contexts because the participants’ desire to be viewed positively may have biased the results. Not wanting to be perceived as having overly high or low self-esteem may have biased the correlation. The literature does support that negative feedback, especially when targeted at an important aspect to the self, reduces self-esteem. Positive feedback, especially about an important aspect of the self, increases self-esteem (Branscombe & Wann, 1994).

Despite the conflicting research, other researchers still give merit to the original self-esteem hypothesis. Crocker, Blaine, and Luhtanen (1993) believe that high self-esteem individuals are motivated by positive future outcomes while low self-esteem individuals are motivated by self-protection. In addition, they argue that high self-esteem individuals will positively rate their ingroup as opposed to engaging in outgroup derogation, while low self-esteem individuals will discriminate against the outgroup rather than optimistically rate their ingroup.

One of the studies testing the self-esteem hypothesis was conducted by Branscombe and Wann (1994), who created their own model that incorporated both corollaries into the self-esteem processes regarding social identity. They proposed that self-esteem created by group memberships depends on the strength of the individual’s social identification and the extent of the meaning that the group creates for the individual. Individuals who highly identify with their social group should be more likely to self-enhance their own group under successful group conditions, but when the group fails, they should be more likely to engage in outgroup derogation. Additionally, individuals with varying self-esteem levels are motivated by different goals. High self-
esteem individuals try to self-enhance and boost their successes, while low self-esteem individuals are more defensive and attempt to self-protect against the threat of failure.

For that reason, Branscombe and Wann’s (1994) model posits outgroup derogation will most likely result from a threat to the group identity and will be used for defensive purposes. The most discrimination will be demonstrated by individuals whose self-esteem has been lowered the most by the threat, especially when targeted at an important aspect of self. However, in the no-threat condition, individuals with a high self-esteem are expected to discriminate the most as a way to self-enhance. They also suggest that derogation will be affected by the type of outgroup. If a particular outgroup especially threatens one’s social identity, discrimination may be the only way to restore self-esteem.

Their study included 40 female undergraduate students who were asked if they had previously seen the movie *Rocky IV*, and to rate the frequency they experience pride in being Americans on a scale of 1 (infrequent) to 8 (frequent). Participants from both extremes of the scale and those who had not previously seen *Rocky IV* were asked to participate in the study. Using a 2 x 2 between-subjects design, there were four conditions: high or low identification with America vs. identity-threatening or no-threat situation. Half of the participants in each condition watched a short clip from *Rocky IV* in which the American fighter defeated the Soviet (no-threat), and the other half watched a clip in which the Soviet fighter defeated the American (identity-threat).

After viewing the film, they were given a questionnaire that allowed the participants to detach themselves from Russians (relevant-outgroup) and other
nationalities (irrelevant-outgroups). They were given statements about the outgroups and were asked to rate the extent to which they agreed on a scale of 1 to 8, with higher numbers indicating a strong desire to distance themselves. Statements about the relevant-outgroup covered topics from the U.S.-Soviet space program to whether or not Russian artists should be allowed to display their work in America. Statements about the irrelevant-outgroups like France, China, and Mexico were used to gauge the desire to maintain distance from other national groups. Also, collective self-esteem was measured directly after the film ended and again after participants had taken the questionnaire.

The results showed that those in either the identity-threatening condition or the no-threat condition who highly identified with being American derogated the most against both the relevant and irrelevant outgroups. Surprisingly, their self-esteem only increased significantly when discriminating against the relevant-outgroup, and it actually decreased when derogating against the irrelevant-outgroup. Thus, the results support Branscombe and Wann’s hypotheses, and they suggest engaging in outgroup derogation most likely happens when an important aspect of self is threatened, which results in increased self-esteem.

Based on the literature about social identity theory and the self-esteem hypothesis, it can be asserted that if an individual does not socially identify with mental illness, then they could view the mentally ill as an outgroup. Mental illness is a factor when considering social identity and group membership (Hoffner & Cohen, 2012). This is significant because the stigma associated with the mentally ill makes them a threat to people’s social identity, and most people would not want to claim membership to this
particular social group. Viewing negative television portrayals possibly facilitates this process further. Watching television gives people the opportunity to compare themselves to outgroups, and in some cases this means comparing themselves to mentally ill characters. Accordingly, as a way to boost self-esteem, people could potentially feed off the negative media portrayals and socially discriminate against the mentally ill, which only further perpetrates stigma and prejudice. Therefore, the self-esteem hypothesis tells us that having low self-esteem, in combination with watching negative television portrayals could perhaps foster negative attitudes about the mentally ill as a way to self-protect if one does not socially identify with them.

THE PRESENT STUDY

The present study is based on the past research that examined the effects on attitudes in response to television portrayals of the mentally ill, and was approved by the Kent State Institutional Review Board for Human Subjects Research (see Appendix A). It is already proven that television overdramatizes mental illness and creates a twisted view about the dangerousness and violent nature of the mentally ill. In turn, this fosters negative attitudes and false beliefs, which in turn create stereotypes about mental illness. This current investigation will add to the research by analyzing how television viewing habits and self-esteem, as described by the social identity theory and self-esteem hypothesis, have an effect on mental illness attitudes. The following hypotheses will be tested:

1. The more one watches television, the more negative their attitudes will be towards the mentally ill.
2. The lower one’s self-esteem, the more negative their attitudes will be toward the mentally ill.

3. Individuals who watch the greatest amount of television and have the lowest self-esteem will have the most negative attitudes toward the mentally ill.

**METHODS**

*Participants.* The 121 participants in this study were Kent State University at Stark students, ranging in age from 17 to 54, with the average age being 22.6 and a standard deviation of 5.9. There were 65 female participants (53.7%) and 56 male participants (46.3%). There were 38 seniors (31.4%), 32 juniors (31.4%), 20 sophomores (16.5%), 30 freshmen (24.8%), and one senior guest. In addition, there were 108 Caucasian participants (89.3%) followed by 3 Hispanic or Latino (2.5%), 3 African American (2.5%), 1 American Indian (.8%), 1 Asian (.8%), and 5 that did not specify an ethnicity (4.1%). Two students reported more than one ethnicity and were sorted into the Other category. Declared college majors were extremely diverse. The bulk of the participants majored in Marketing (19%), History (14.9%), Psychology (15.7%), Business Management (9.9%), and Nursing (9.1%). Other majors included Accounting (.8%), Applied Communications (.8%), Business (.8%), Business Administration and Finance (.8%), Chemistry (.8%), Computer Science (.8%), Criminal Justice (2.5%), Criminal Justice and Psychology (.8%), Early Childhood Education (.8%), Education (1.7%), English and Psychology (.8%), Entrepreneurship (.8%), Exercise Science (.8%), Exploratory (.8%), Human Development and Family Studies (1.7%), Healthcare
Administration (.8%), Human Development (.8%), Marketing and English (.8%), Nutrition (.8%), Pharmacy (.8%), Photo Journalism (.8%), Physics (.8%), Public Relations and Photo Illustrations (.8%), Social Studies (.8%), Spanish and Math (.8%), Spanish Culture, Literature, and Translation (.8%), Undecided (3.3%), and World History (.8%).

Measures

**Researcher-Created Survey.** Students were asked to take three questionnaires. The first was a researcher-created survey based on the study by Granello and Pauley (2000) that collected demographic information and television viewing habits, including how many hours of television watched per week, the most commonly watched genre of television show, and individuals primary information source about mental illness. On the questions asking participants to compare their television viewing habits to others, a 5-point Likert scale was used. Students were asked to choose an answer ranging from 1 (a lot less) to 5 (a lot more). Other questions inquiring about the most common types of television programs watched only required participants to circle one or multiple answers, while another asked them to list their most commonly watched television shows and to indicate for each how many hours they watched them per week. The question determining where the participants receive their mental illness knowledge from required them to rank their top three sources, with a rank of 1 indicating their primary information source and a rank of 3 indication an occasional information source. Last, they were asked to list any relevant courses taken previously that provided knowledge on mental illness.
Rosenberg’s Self-Esteem Scale. Self-esteem was measured with Rosenberg’s Self-Esteem Scale, a 10-question survey measured on a 4-point Likert scale. Answers ranged from strongly disagree (1) to strongly agree (4), and five of the statements were reverse scored. The highest score a participant can receive is a 40 and the lowest score a participant can receive is a 10. The lower the score, the lower the self esteem and vice-versa.

The Self-Esteem Scale (Rosenberg, 1965) shows adequate reliability and validity. Validity is the extent to which a test measures what it claims to measure, often demonstrated with correlations with other constructs, and reliability is the consistency of a test to measure the same way each time used. Internal consistency on Rosenberg’s Self-Esteem Scale ranges from .77 to .88 and its test-retest ranges from .82 to .85; coefficients above .70 are considered acceptable. As would be predicted, the scale correlated -.64 with anxiety, -.54 with depression, and -.43 with anomie, or social instability resulting from a breakdown of standards and values (Rosenberg, 1965).

Community Attitudes on the Mentally Ill. Last, students were asked to take the Community Attitudes on the Mentally Ill (CAMI) to assess their feelings about mental illness. This 40-item questionnaire created by Taylor and Dear (1981) is based off a 5-point Likert Scale. Answers ranged from strongly disagree (1) to strongly agree (5), with half of the questions reverse scored. Questions measure attitudes about the mentally ill across four subscales: Authoritarianism, Benevolence, Social Restrictiveness, and Mental Health Ideology. There is a total range of 10-50 points possible to be earned within each subscale. Higher scores indicate an agreement with the construct being measured.
Overall, a tolerant person would be likely to score high on the Community Mental Health Ideology and Benevolence subscales and low in Social Restrictiveness and Authoritarianism. Further, each subscale is broken down into a pro-subscale or an anti-subscale, meaning there are certain questions that specifically measure agreement or disagreement within that one subscale. The subscales on the CAMI that measure negative attitudes are pro-social restrictiveness, pro-authoritarianism, anti-benevolence, and anti-community mental health ideology. The subscales that measure positive attitudes are anti-social restrictiveness, anti-authoritarianism, pro-benevolence, and pro-community mental health ideology. For example, a participant could score high in the anti-authoritarian subscale and high in the pro-benevolence subscale, which would indicate a tolerant attitude. The subscales and what they measure are broken down as follows:

**Authoritarianism Subscale:** Measures feelings of superiority over those with a mental illness. Agreement within this subscale indicates a belief in the need to hospitalize all mentally ill because they do not belong within society. A sample statement on the CAMI could include, “Mental illness is an illness like any other.”

**Benevolence Subscale:** Measures sympathetic views of the mentally ill. This view is largely based on humanistic and religious attitudes. Agreement within this subscale indicates the belief that the community is responsible for taking care of the mentally ill, with everyone having a responsibility to be kind and gentle to them. A sample statement on the CAMI could include, “The mentally ill have for too long been the subject of ridicule.”
Social Restrictiveness Subscale: Measures beliefs about the violent and dangerous nature of the mentally ill. Agreement within this subscale indicates a belief that the mentally ill are a threat to society and everyone should keep a safe distance from them. A sample statement on the CAMI could include, “The mentally ill should be isolated from the rest of the community.”

Mental Health Ideology Subscale: Measures one’s view regarding traditional care verses non-traditional care. A belief in traditional care would favor institutionalizing the mentally ill while favoring community-based care would favor deinstitutionalized care. A sample statement on the CAMI could include, “The best therapy for mental health patients is to be part of the normal community.”

Taylor and Dear (1981) also reported the psychometrics of the CAMI subscales. Three of the four subscales are highly reliable. The Cronbach’s alpha reliabilities were as follows: Authoritarianism—.68, Benevolence—.76, Social Restrictiveness—.80, and Community Mental Health—.88. They also reported on the validity of the scale. The scale validities were reported using Pearson moment products. Authoritarianism and benevolence were correlated at -.63, authoritarianism and social restrictiveness at .72, authoritarianism and community mental health ideology at -.64, benevolence and social restrictiveness at -.65, benevolence and community mental health ideology at .65, and social restrictiveness and community mental health ideology at -.77. The literature generally has shown that the scale is related to social distancing behavior.

Procedure
The three surveys—television habits survey, Rosenberg’s Self-Esteem Scale, and the CAMI (available in Appendix B)—were passed out to Kent State Stark students during one of their regularly scheduled classes after getting permission from the Kent Stark faculty. They were told they were participating in a study that was analyzing television and personality. The instruments took between 10 to 15 minutes to complete and were turned in at the end of class. Once the surveys were collected, they were coded and entered into the Statistical Package for the Social Sciences (SPSS; version 22) for analysis.

RESULTS

Prior to data analysis, all responses were viewed for data input errors and extreme values that would negatively affect statistical analyses. First, when a participant reported watching over 100 hours per week in the past month, their data was made a missing value in the analysis because extreme value could skew the results and not accurately reflect the true amount of television watched. Second, two participants circled more than one ethnicity on the researcher-created survey, and therefore they were included in the other category of the analysis. Third, one participant completed Rosenberg’s Self-Esteem Scale incorrectly, circling two answers for the same question. Therefore, those two questions for that participant were removed from the analysis. Last, the question asking respondents to rank their top three primary sources of information had data removed or altered for various reasons. If a participant only used check marks to indicate their sources, the data was deleted or modified in some way because their ranks could not be differentiated. If
they responded with only 2 check marks, their answers were changed to a rank of 1 in the analysis. If they had more than 3 check marks, the data was removed from the analysis. However, if the participant indicated more than one top primary source of information, only their number 1 ranks were entered into analysis and their other ranks were removed. If the participant indicated more than three top primary sources, their data was removed from analysis.

As seen in Table 1, students watched an average of 9.89 hours of television per week with a range of 0-50 hours. The mean hours of television watched per week reported in the last month were 18.75 with a range from 0-80 and a median of 6. The average score on the self-esteem measure was a 30.7, with a range of scores from 14 to 40.

---

Table 1. Table of Means and Standard Deviations

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Television watched per week</td>
<td>9.8</td>
<td>9.4</td>
</tr>
<tr>
<td>Television watched per week—past month</td>
<td>18.7</td>
<td>17.2</td>
</tr>
<tr>
<td>Rosenberg’s Self-Esteem Scale</td>
<td>30.7</td>
<td>5.8</td>
</tr>
<tr>
<td>Community Attitudes on the Mentally Ill Scale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pro Authoritarian Subscale</td>
<td>11.9</td>
<td>5.8</td>
</tr>
<tr>
<td>Pro Benevolence Subscale</td>
<td>18.9</td>
<td>2.8</td>
</tr>
<tr>
<td>Pro Social Restrictiveness Subscale</td>
<td>11.0</td>
<td>3.4</td>
</tr>
<tr>
<td>Pro Community Mental Health Subscale</td>
<td>18.0</td>
<td>2.8</td>
</tr>
<tr>
<td>Anti Authoritarian Subscale</td>
<td>17.7</td>
<td>2.7</td>
</tr>
<tr>
<td>Anti Benevolence Subscale</td>
<td>10.4</td>
<td>2.7</td>
</tr>
<tr>
<td>Anti Social Restrictiveness Subscale</td>
<td>17.7</td>
<td>3.0</td>
</tr>
<tr>
<td>Anti Community Mental Health Subscale</td>
<td>12.5</td>
<td>3.4</td>
</tr>
</tbody>
</table>
Each main subscale is broken down into a pro-subscale or an anti-subscale, meaning there are certain questions that specifically measure agreement or disagreement within that one subscale. The subscales on the CAMI that measure negative attitudes toward the mentally ill are pro-social restrictiveness, pro-authoritarianism, anti-benevolence, and anti-community mental health ideology. The subscales that measure positive attitudes toward the mentally ill are anti-social restrictiveness, anti-authoritarianism, pro-benevolence, and pro-community mental health ideology. Higher scores indicate agreement with the construct being measured. The average score on the pro-authoritarian subscale was 11.9, pro-benevolence was 18.9, pro-social restrictiveness was 11.0, and pro-community mental health ideology was 18.0. Within the anti-subscases, the average on anti-authoritarian was 17.7, anti-benevolence was 10.4, anti-social restrictiveness was 17.7, and anti-community mental health was 12.5.

Common types of television shows and programs watched were reported as follows: sitcoms (52.1%), music television (6.6%), daytime soap operas (5.0%), television movies (31.4%), sports (29.8%), news (33.1%), dramas (39.7%), daytime talk shows (8.3%), late night programming (23.1%), cartoons (25.6%), science fiction (33.1%), reality shows (38.8%), and 15 subjects reported other types of shows. Top shows most frequently watched were The Big Bang Theory (15.7%), American Dad (4.1%), Breaking Bad (7.4%), COPS (4.1%), Criminal Minds (4.9%), Duck Dynasty (4.1%), Family Guy (8.2%), Friends (6.6%), Game of Thrones (4.9%), Grey’s Anatomy (6.6%), How I Met Your Mother (10.7%), Law and Order: SVU (6.6%), Modern Family
(4.9%), News Channels (11.5%), Pretty Little Liars (9.0%), South Park (5.7%), Sports Center (9.0%), and The Walking Dead (17.3%).

The analysis showed that 68 participants (68.7%) had past experience with mental illness through at least one college course, 18 participants (18.2%) had no prior coursework or knowledge, 11 participants (11.1%) had experience through four or more college courses, 1 participant (1.0%) had a mix of psychology classes with other types of courses, and 1 participant (1.0%) worked with the mentally ill. There were 22 participants that left this question blank on the survey; therefore they are not included in this data.

Regarding participants’ information source about the mentally ill, they were asked to rank their top three sources most commonly used. The following frequencies include all three ranks assigned to the specific category: 18 (17.4%) had a parent with a diagnosable mental illness, 12 (11.2%) had a sibling with a diagnosable mental illness, 15 (13.9%) had a close friend with a diagnosable mental illness, 19 (17.8%) had an extended family member with a diagnosable mental illness, 5 (4.7%) work with the mentally ill, 4 (3.7%) had an acquaintance with a diagnosable mental illness, 42 (38.9%) reported television as a source, 6 (5.6%) said radio, 78 (70.8%) said internet, 18 (16.8%) said movies and films, 18 (16.8%) said print media, 52 (48.6%) said their college coursework, 11 (10%) reported they had a diagnosable mental illness, and 9 participants reported other sources.

**Hypothesis 1.** The more one watches television, the more negative their attitudes will be towards the mentally ill.
The subscales on the CAMI that measure negative attitudes are pro-social restrictiveness, pro-autoritarianism, anti-benevolence, and anti-community mental health ideology. High scores within these constructs indicate an agreement within the subscale, meaning they are intolerant of the mentally ill. If the results are to support the hypothesis, there needs to be a negative correlation between the mentioned subscales and television watched because that would suggest an agreement within the subscale, therefore signifying negative attitudes while also having low self-esteem.

Pearson product moment correlations were computed to test this hypothesis (See Table 2 below). These correlations used reported hours of television watched in the past week over the past month as a better predictor of habitual behavior. Additionally, correlations with reported number of hours of television watched in the past week were not significant and were not included in the tables. Correlating hours of television watched per week in the past month with the pro-authoritarianism subscale produces a correlation coefficient .086 and a -.040 within the pro-social restrictiveness subscale.

Table 2. Table of Correlations among Variables Measuring Intolerance

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Television watched (past month)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Rosenberg’s Self-Esteem Scale</td>
<td>-.012</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Pro Authoritarian</td>
<td>.086</td>
<td>-.022</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Anti-Benevolence</td>
<td>-.088</td>
<td>.074</td>
<td>.575**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Pro Social Restrictiveness</td>
<td>-.040</td>
<td>.288**</td>
<td>.470**</td>
<td>.650**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Anti Community Mental Health</td>
<td>-.162</td>
<td>.158</td>
<td>.460**</td>
<td>.631**</td>
<td>.572**</td>
<td></td>
</tr>
</tbody>
</table>

*Correlation is significant at the 0.05 level (2-tailed)
**Correlation is significant at the 0.01 level (2-tailed)
The correlations are fairly weak within both subscales, and the correlation for the pro-social restrictiveness subscale actually is the opposite of what was predicted. However, the correlation between television watching and the pro-authoritarianism subscale is positive, albeit not significant. When paired with television watched per week in the past month, the correlation with anti-benevolence is -.088 and with anti-community mental health ideology is -.162. None of the correlations were significant, some were extremely weak, and in some cases, they show the opposite of the hypothesis. Thus, hypothesis 1 was not supported.

**Hypothesis 2.** The lower one’s self-esteem, the more negative their attitudes will be toward the mentally ill.

Table 3 shows the Pearson moment product correlations between self-esteem and the subscales on the CAMI measuring tolerance of the mentally ill. The table shows us that anti-authoritarianism and self-esteem were correlated at -.237 (p<.01), pro-benevolence and self-esteem at -.227 (p<.05), pro-social restrictiveness at .288 (p<.01), and pro-community mental health ideology at -.184 (p<.05).

These findings show the opposite of what was predicted. The higher a participant’s self-esteem, the higher they scored within the social restrictiveness subscale, suggesting intolerance toward the mentally ill. The lower the participant’s self-esteem the higher they scored within the tolerant subscales, suggesting tolerance toward the mentally ill. The correlations between self-esteem and the subscales that measure negative
attitudes would have needed to be positively correlated, which they were not. This suggests that high self-esteem, rather than low self-esteem, may be a better indicator of intolerance. Thus, hypothesis 2 was not supported.

Table 3. Table of Correlations among Variables that Measure Tolerance

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Television watched (past month)</td>
<td></td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Rosenberg’s Self-Esteem Scale</td>
<td>-.012</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Anti Authoritarian</td>
<td>.162</td>
<td>-.237**</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Pro Benevolence</td>
<td>.213*</td>
<td>-.227*</td>
<td>.452*</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Anti Social Restrictiveness</td>
<td>.237*</td>
<td>-.069</td>
<td>.566**</td>
<td>.609**</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>6. Pro Community Mental Health</td>
<td>.269**</td>
<td>-.184*</td>
<td>.483**</td>
<td>.606**</td>
<td>.645**</td>
<td>-</td>
</tr>
</tbody>
</table>

*Correlation is significant at the 0.05 level (2-tailed)
**Correlation is significant at the 0.01 level (2-tailed)

Hypothesis 3. Individuals who watch the greatest amount of television and have the lowest self-esteem will have the most negative attitudes toward the mentally ill.

To test this hypothesis, participants were split into two groups and their means (see Table 4) were compared using an independent samples t-test. Group 1 includes the participants that watched more than 11 hours of television per week and scored a 28 or below on Rosenberg’s Self-Esteem scale, which reflects those participants who watched the most television and had the lowest self-esteem. Group 2 are those that watch more than 11 hours of television per week, but scored a 33 or above on Rosenberg’s Self-Esteem Scale. Included in Group 2 are also those that watched 10 of fewer hours of television per week, regardless of self-esteem.
Table 4. *Group Statistics Used in the Independent Samples T-Test*

<table>
<thead>
<tr>
<th></th>
<th>Group 1&lt;sup&gt;a&lt;/sup&gt;</th>
<th></th>
<th>Group 2&lt;sup&gt;b&lt;/sup&gt;</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>1. Anti Authoritarian</td>
<td>18.36</td>
<td>3.35</td>
<td>17.67</td>
<td>2.65</td>
</tr>
<tr>
<td>2. Anti Benevolence</td>
<td>10.66</td>
<td>2.74</td>
<td>10.22</td>
<td>2.88</td>
</tr>
<tr>
<td>3. Anti Social Restrictiveness</td>
<td>17.94</td>
<td>4.10</td>
<td>17.75</td>
<td>3.05</td>
</tr>
<tr>
<td>4. Anti Community Mental Health</td>
<td>12.31</td>
<td>3.90</td>
<td>12.65</td>
<td>3.56</td>
</tr>
<tr>
<td>5. Pro Authoritarian</td>
<td>11.78</td>
<td>4.31</td>
<td>11.57</td>
<td>3.28</td>
</tr>
<tr>
<td>6. Pro Benevolence</td>
<td>19.94</td>
<td>2.34</td>
<td>18.92</td>
<td>3.08</td>
</tr>
<tr>
<td>7. Pro Social Restrictiveness</td>
<td>10.73</td>
<td>4.66</td>
<td>10.97</td>
<td>3.31</td>
</tr>
<tr>
<td>8. Pro Community Mental Health</td>
<td>18.94</td>
<td>2.85</td>
<td>17.84</td>
<td>2.98</td>
</tr>
</tbody>
</table>

<sup>a</sup>Participants that watched more than 11 hours of television per week and scored a 28 or below on Rosenberg’s Self-Esteem scale.

<sup>b</sup>Participants that watched more than 11 hours of television per week, but scored a 33 or above on Rosenberg’s Self-Esteem Scale. Included in Group 2 are also those that watched 10 of fewer hours of television per week, regardless of self-esteem.

As a review of the means in Table 4 show, those who watched the most television and had the lowest self-esteem did not differ substantially from other participants on the CAMI scales. The results of the t-tests confirm this observation (see Table 5); none of the tests yielded significant results. The p-values were not close to being significant, suggesting that there is not an interaction between low self-esteem, television watching, and negative attitudes. Thus, hypothesis 3 was not supported.
Table 5. *T*-Values, *P*-Values, and Degrees of Freedom for Each CAMI Subscale

<table>
<thead>
<tr>
<th>Scale</th>
<th>T-Value</th>
<th>d.f.(^a)</th>
<th>p-Value(^b)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Anti Authoritarian</td>
<td>.970</td>
<td>93</td>
<td>.335</td>
</tr>
<tr>
<td>2. Anti Benevolence</td>
<td>.591</td>
<td>92</td>
<td>.556</td>
</tr>
<tr>
<td>3. Anti Social Restrictiveness</td>
<td>.235</td>
<td>93</td>
<td>.815</td>
</tr>
<tr>
<td>4. Anti Community Mental Health Ideology</td>
<td>-.367</td>
<td>93</td>
<td>.714</td>
</tr>
<tr>
<td>5. Pro Authoritarian</td>
<td>.234</td>
<td>93</td>
<td>.815</td>
</tr>
<tr>
<td>6. Pro Benevolence</td>
<td>1.35</td>
<td>93</td>
<td>.179</td>
</tr>
<tr>
<td>7. Pro Social Restrictiveness</td>
<td>-.254</td>
<td>92</td>
<td>.800</td>
</tr>
<tr>
<td>8. Pro Community Mental Health Ideology</td>
<td>1.45</td>
<td>93</td>
<td>.149</td>
</tr>
</tbody>
</table>

\(^a\)Degrees of Freedom
\(^b\)p<.05

DISCUSSION

The primary purpose of this study was to establish a correlation between watching television, low self-esteem levels, and negative attitudes about the mentally ill. Analyses showed no correlation between watching television and having negative attitudes about the mentally ill. In addition, there was no correlation between low self-esteem levels and attitudes about the mentally ill. Last, there was no interaction between watching television, low self-esteem, and attitudes about the mentally ill. The results of the study were surprising, especially due to the fact that studies have proven the negative effects of television on attitudes about the mentally ill. These results contradicted many of the
studies cited in the literature review, particularly Granello et al. (1999) and Granello & Pauley (2000).

**Hypothesis 1.** The more one watches television, the more negative their attitudes will be towards the mentally ill.

Numerous past studies have clearly established that watching television has a negative effect on attitudes, particularly about the mentally ill. However, the present analysis produced a weak correlation between these two variables in this study, suggesting there is no interaction between watching television and having negative attitudes about the mentally ill. In fact, most of the correlations were not significant at all, which again contradicts past findings.

It also challenges established mass communication and social psychology theories. In review, the three theories relevant to this hypothesis’ findings are transportation theory, social learning theory, and cultivation theory. Transportation theory posits that viewers perceive what they see on television to be real, and therefore are more easily persuaded and adopt other views that are being presented. The study by Caputo and Rouner (2011) evidently established that viewers of *Prozac Nation* displayed greater social distancing behavior towards the mentally ill, which shows that being transported into a visual medium can directly cause negative attitudes. This present study disputed those findings along with other past studies including Granello et al. (1999) and Granello & Pauley (2000). However, the present study did use a survey method as opposed to an experimental design, which may account for the different results.
Next, cultivation theory says that exposure to media on a regular basis will foster certain ideas and attitudes that are being portrayed. The media “cultivates” views and biases that will eventually be supposed as reality to the audience. As shown in the literature review, there are expansive numbers of studies that show television portrays the mentally ill as dangerous, childlike, and unpredictable, and generally promote a negative view of them. Logically, these ideas should take root in the viewers and be “cultivated” as their reality, which should produce negative attitudes about the mentally ill. Cultivation theory works in tandem with social learning theory, which posits that learning can be a result of direct observation and experience. When viewers watch television, they see the mentally ill being depicted as dangerous and they also see how others treat them. Social conventions are learned by watching television, and many people treat the mentally ill negatively because of what they view on television. When one does not have experience with mental illness, they learn how to interact with the mentally ill by what they see on television—social learning theory—and when they repeatedly see the same behavior towards the mentally ill, they believe that it is socially acceptable behavior—cultivation theory. Again, according to these theories, television viewers should hold negative attitudes about the mentally ill because they are the most familiar with the inaccurate representations that are presented by the media. The findings of this present study contradict these theories and suggest that previous personal experience with mentally ill can counter these effects. Overall, the results of hypothesis 1 were not expected and contradict established findings.
Hypothesis 2. The lower one’s self-esteem, the more negative their attitudes will be toward the mentally ill.

Results for this hypothesis showed there was no correlation between low self-esteem and negative attitudes about the mentally ill. The relevant theory applied to this hypothesis is the social identity theory, which states one’s own social identity is determined by what social groups one relates to. When considering group membership, one may reflect on age, race, political party, or other factors that are important to the individual. Belonging to collective groups increase self-esteem because it allows intergroup comparisons and provides psychological benefits. To raise self-esteem, one can compare themselves to someone else in their own group or they can compare themselves to an outgroup. Abrams and Hogg (1988) further this theory by proposing the self-esteem hypothesis to be considered: (1) inner-group discrimination increases self-esteem and (2) threatened or low self-esteem increases out-group discrimination. The past research on this hypothesis is inconsistent and mixed. The majority of the studies do provide support for Corollary 1 of the self-esteem hypothesis as opposed to Corollary 2, which is what this present study was testing. This present study’s findings directly oppose Corollary 2, suggesting that high self-esteem is a better predictor of negative attitudes. These results also oppose the study completed by Branscombe and Wann (1994) testing their own model that incorporated both corollaries of the self-esteem hypothesis as it relates to social identity. They hypothesized that high self-esteem individuals try to self-enhance and boost their successes, while low self-esteem individuals are more defensive and attempt to self-protect against the threat of failure. These present results prove half of
the model true. Again, the analysis showed that high self-esteem was a better predictor of negative attitudes of the mentally ill as opposed to low self-esteem. In fact, it seemed to be the opposite of what was predicted. Those with lower self-esteem had a more positive view and those with high self-esteem had a more negative view toward the mentally ill. Reasons for this could vary based on many different factors. One explanation could be that since the participants themselves had low self-esteem, they hold more positive views of others because they themselves would not want to be viewed negatively. It could be said the participants were showing a type of empathy toward the mentally ill, and maybe this form of empathy biased the results. Further research would be needed to test this. Overall, results of the analysis for hypothesis 2 were not expected.

**Hypothesis 3.** Individuals who watch the greatest amount of television and have the lowest self-esteem will have the most negative attitudes toward the mentally ill.

This prediction again addresses all the theories laid out in the literature review: transportation theory, social learning theory, cultivation theory, and social identification theory which includes the self-esteem hypothesis. According to all of these mass communication and social psychology theories, the basic premise is that those who watch television will hold more negative views of the mentally ill because they believe those representations to be a reflection of the real world. Adding in the self-esteem hypothesis furthers this by saying those that have low self-esteem will discriminate against the mentally ill as a defense mechanism. Plausibly, individuals that have the lowest levels of self-esteem and watch the most amount of television should hold the most negative views of the mentally ill in general. However, the findings of the present study do not support
this and show there is no interaction between these three variables. This is surprising given all of the literature and research supporting these three ideas separately. It only made sense to add them all together to determine if there was an interaction. Because there were no significant findings with hypothesis 3, this suggests that high self-esteem is a better predictor of negative attitudes, and it possibly says that having previous exposure to the mentally ill can counteract the effects of watching television. Overall, the findings of hypothesis 3 were unexpected.

Alternate Explanations of Findings. Though the hypotheses were not supported, the data regarding participants’ source on mental illness could provide some answers as to why. More than half (60.3%) reported having a family member, parent, sibling, or close friend with a diagnosable mental illness. This could imply why the analysis showed more positive attitudes toward the mentally ill, despite how much television was watched by the individuals. Also, the overall self-esteem levels of the participants were fairly high, scoring an average of 30.7 out of 40 possible points on the self-esteem measure. The results may have been different if the majority of students had low self-esteem. In addition, nearly half (48.6%) of the students had taken some type of coursework that provided information about the mentally ill. College students may naturally have a more positive attitude toward the mentally ill because they are more educated and naturally knowledgeable about them.

Limitations. With all survey research, there are limitations that cannot be avoided. While surveys are quick to complete and analyze, there is always a risk of bias in the answers provided by the participants. The results could be skewed due to the fact that
participants may distort some of their answers on questions to make themselves feel and look better to the researcher. The surveys were also limited to Kent State Stark students and the analysis may have been different if a larger population had been included.

Similarly, most of the participants were younger and of college-age. If the study wouldn’t have been fairly limited to this age group, different outcomes may have been achieved.

This specific study also only collected a set of data from one group of people at one point in time. This limited what types of people were included in the study and limited what opinions were shown in the analysis. Additionally, the questions about the mentally ill were very general and vague. Answers about some of the situations and opinions asked could have varied according to what type of mental illness was being referred to.

Responses may have been more extreme if the questions addressed schizophrenia or antisocial personality disorder specifically, rather than equating them on the same level as depression.

If this study were to be conducted a second time, it could be beneficial to create a pre-test/post-test control group design. That would potentially allow determination of participants’ self-esteem and attitudes before applying a stimulus—a television show—and then a measure afterwards would allow a comparison. It may also help the results if participants who have personal ties, like a family member with mental illness, were left out of the analysis to ensure there are no biases. Additionally, testing how high self-esteem is correlated with watching television and attitudes would be another possibility for future research. As well, future studies could address the interaction between types of television shows watched, self-esteem, and attitudes about the mentally ill. This could
make it easier for advocate groups to pinpoint which programs are promoting stigma and discrimination against the mentally ill. Other researchers may also consider interviewing participants themselves to gauge better their opinions and attitudes. In-person interviewing would make it harder for participants to hide their emotions and to lie about their true attitudes. Future studies may also consider defining mental illness in a certain way for participants before they take a survey measuring their attitudes. For example, one group may be told that mental illness is referring to anxiety disorders while another group may be told mental illness is referring to borderline personality disorder. This could allow for comparison and to determine if people are more biased against certain disorders. Further research in this particular area is abundant as previously listed and current research has much room to be expanded upon.

**Conclusion.** In general, the results of the study showed the opposite of what was predicted. Despite extensive research proving that television depicts the mentally ill in an extremely negative light, the results showed that the majority of respondents had positive views of the mentally ill. High self-esteem seemed to be a better indicator of negative attitudes about the mentally ill and low self-esteem was a better predictor of positive attitudes. This implies that previous exposure to the mentally ill has a possible positive effect on attitudes, whether through personal experience, schoolwork, or through a job.

This means that the established mass communication theories and social psychology theories that are associated with the media and its effects can be contradicted when other outside variables are present. This is important because media is in everyone’s lives on a daily basis and this provides hope that there are ways to counter
what shows are suggesting to viewers. It shows that the media does not have complete control. There are ways to fight the stigma surrounding having a mental illness, which this study reveals. Ultimately, the results of the study were surprising and unanticipated. However, they show that experience with mental illness can foster positive attitudes about the mentally ill, which is a step in the right direction. Future studies should continue to look at this relationship between the media and mental illness to help further reduce stigma attached to having a mental illness.
References


Goldstein, B. K. (1979). Television portrayals of mentally disturbed deviants in prime-


IRB Level I, category 2 approval for Protocol application #14-106 - please retain this email for your records

The Kent State University Institutional Review Board has reviewed and approved your Application for Approval to Use Human Research Participants as Level I/Exempt from Annual review research. Your research project involves minimal risk to human subjects and meets the criteria for the following category of exemption under federal regulations:

- Exemption 2: Educational Tests, Surveys, Interviews, and Public Behavior Observations

This application was approved on February 18, 2014.

***Submission of annual review reports is not required for Level I/Exempt projects.

If any modifications are made in research design, methodology, or procedures that increase the risks to subjects or includes activities that do not fall within the approved exemption category, those modifications must be submitted to and approved by the IRB before implementation.

Please contact an IRB discipline specific reviewer or the Office of Research Compliance to discuss the changes and whether a new application must be submitted. [http://www.kent.edu/research/researchsafetyandcompliance/irb/index.cfm](http://www.kent.edu/research/researchsafetyandcompliance/irb/index.cfm)
Kent State University has a Federal Wide Assurance on file with the Office for Human Research Protections (OHRP); FWA Number 00001853.

If you have any questions or concerns, please contact us at Researchcomplaince@kent.edu or by phone at 330-672-2704 or 330.672.8058.

Respectfully,
Kent State University Office of Research Compliance
224 Cartwright Hall | fax 330.672.2658

Kevin McCreary | Research Compliance Coordinator
| 330.672.8058 | kmccrea1@kent.edu
Paulette Washko | Manager, Research Compliance | 330.672.2704 | Pwashko@kent.edu

For links to obtain general information, access forms, and complete required training, visit our website at www.kent.edu/research.
Instructions: The following survey is being conducted for academic and scholarly purposes only. There are no right or wrong answers, so be as truthful as possible. All answers are completely confidential and no one will know individual’s answers. Choose answers that best fit.

1. Major: ________________________________

2. Year in college (circle response): Freshman(1) Sophomore(2) Junior(3) Senior(4)

3. Gender (circle response): Male(0) Female(1)

4. Age: ___________

5. Ethnicity (circle response):
   Hispanic or Latino(1) Caucasian(2) African American(3) American Indian(4)
   Native Hawaiian(5) Pacific Islander(6) Asian(7) Native Alaskan(8)
   Other(9)

6. On average, how many hours did you spend watching television this past week? _________

7. On average, how many hours per week in the past month did you watch television? _________

8. Compared to others, how much television do you watch? (Circle number)
   5  4  3  2  1
   A lot more  A little more  The same  A little less  A lot less

9. Compared to others, how much television did you watch as a child? (Circle number)
   5  4  3  2  1
   A lot more  A little more  The same  A little less  A lot less

10. Compared to others, how much television did you watch as an adolescent? (Circle number)
    5  4  3  2  1
    A lot more  A little more  The same  A little less  A lot less
11. Currently, what are the most common types of television programs you watch? Circle numbers for all that apply.

A. Sitcoms
B. Music television
C. Daytime soap operas
D. Television movies
E. Sports
F. News
G. Dramas
H. Daytime talk shows
I. Late night programming
J. Cartoons
K. Science Fiction
L. Reality Shows
M. Other: __________________________
N. Other: __________________________

12. Please list the names of your top five favorite television shows and indicate for each how many hours you watch per week.

<table>
<thead>
<tr>
<th>Show</th>
<th>Hours/Week</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13. Please number your top three sources from where you get your mental illness knowledge. A rank of 1 indicates your primary information source, rank 2 indicates a frequently used source, and rank 3 indicates your occasional information source.

   (A) Parent with a diagnosable mental illness
   (B) Sibling with a diagnosable mental illness
   (C) Close friend with a diagnosable mental illness
   (D) Extended family member with a diagnosable mental illness
   (E) Working with someone with a diagnosable mental illness
   (F) An acquaintance with a diagnosable mental illness
   (G) Television
   (H) Radio
   (I) Internet
   (G) Movies/Films
   (H) Print media (books, magazines, newspapers, etc)
   (I) Coursework or schoolwork
   (J) Self—personally diagnosed with a mental illness
   (K) Other: __________________________

14. List any relevant courses you have taken that provided knowledge on mental illness:
**Instructions:** Below is a list of statements dealing with your general feelings about yourself. If you strongly agree, circle SA. If you agree with the statement, circle A. If you disagree, circle D. If you strongly disagree, circle SD.

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
<th>SA</th>
<th>A</th>
<th>D</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>On the whole, I am satisfied with myself.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>2</td>
<td>At times, I think I am no good at all.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>3</td>
<td>I feel that I have a number of good qualities.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>4</td>
<td>I am able to do things as well as most other people.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>5</td>
<td>I feel I do not have much to be proud of.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>6</td>
<td>I certainly feel useless at times.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>7</td>
<td>I feel that I'm a person of worth, at least on an equal plane with others.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>8</td>
<td>I wish I could have more respect for myself.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>9</td>
<td>All in all, I am inclined to feel that I am a failure.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
</tr>
<tr>
<td>10</td>
<td>I take a positive attitude toward myself.</td>
<td>SA</td>
<td>A</td>
<td>D</td>
<td>SD</td>
</tr>
</tbody>
</table>
The following statements express various opinions about mental illness and the mentally ill. The mentally ill refers to people needing treatment for mental disorders but who are capable of independent living outside a hospital. Please circle the response which most accurately describes your reaction to each statement. It's your first reaction, which is important. Don't be concerned if some statements seem similar to ones you have previously answered. Please be sure to answer all statements.

a. As soon as a person shows signs of mental disturbance, he should be hospitalized.
   SA A N D SD

b. More tax money should be spent on the care and treatment of the mentally ill.
   SA A N D SD

c. The mentally ill should be isolated from the rest of the community.
   SA A N D SD

d. The best therapy for many mental patients is to be part of a normal community.
   SA A N D SD

e. Mental illness is an illness like any other.
   SA A N D SD

f. The mentally ill are a burden on society.
   SA A N D SD

g. The mentally ill are far more of a danger than most people suppose.
   SA A N D SD

h. Locating mental health facilities in a residential area downgrades the neighbourhood.
   SA A N D SD

i. There is something about the mentally ill that makes it difficult to tell them from normal people.
   SA A N D SD

j. The mentally ill have for too long been the subject of ridicule.
   SA A N D SD

k. A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered.
   SA A N D SD

l. As far as possible mental health services should be provided through community-based facilities.
   SA A N D SD

m. Less emphasis should be placed on protecting the public from the mentally ill.
   SA A N D SD

n. Increased spending on mental health services is a waste of tax dollars.
   SA A N D SD

o. No one has the right to exclude the mentally ill from their neighbourhood.
   SA A N D SD

p. Having mental patients living within residential neighbourhoods might be good therapy, but the risks to residents are too great.
   SA A N D SD

q. Mental patients need the same kind of control and discipline as a young child.
   SA A N D SD

r. Local residents have good reason to resist the location of mental health services in their community.
   SA A N D SD

s. We need to adopt a far more tolerant attitude toward the mentally ill in our society.
   SA A N D SD

t. The best way to handle the mentally ill is to keep them behind locked doors.
   SA A N D SD

u. The mentally ill should not be treated as outcasts of society.
   SA A N D SD

v. There are sufficient existing services for the mentally ill.
   SA A N D SD

w. Mental patients should be encouraged to assume the responsibilities of normal life.
   SA A N D SD

x. Local residents have good reason to resist the location of mental health services in their community.
   SA A N D SD

y. Our mental hospitals seem more like prisons than safe places where the mentally ill can be cared for.
   SA A N D SD
aa. Anyone with a history of mental problems should be excluded from taking public office.
SA A N D SD

bb. Locating mental health services in residential neighbourhoods does not endanger local residents.
SA A N D SD

c.c. Mental hospitals are an outdated means of treating the mentally ill.
SA A N D SD

d.d. The mentally ill do not deserve our sympathy.
SA A N D SD

e.e. The mentally ill should not be denied their individual rights.
SA A N D SD

ff. Mental health facilities should be kept out of residential neighbourhoods.
SA A N D SD

gg. One of the main causes of mental illness is a lack of self-discipline and will power.
SA A N D SD

hh. We have the responsibility to provide the best possible care for the mentally ill.
SA A N D SD

ii. The mentally ill should not be given any responsibility.
SA A N D SD

jj. Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services.
SA A N D SD

kk. Virtually anyone can become mentally ill.
SA A N D SD

ll. It is best to avoid anyone who has mental problems.
SA A N D SD

mm. Most women who are once patients in a mental hospital can be trusted as babysitters.
SA A N D SD

nn. It is frightening to think of people with mental problems living in residential neighbourhoods.
SA A N D SD

COMMUNITY ATTITUDES TOWARDS THE MENTALLY ILL

©Copyright 1995, by Michael J. Dear and S. Martin Teyler,
Department of Geography, McMaster University, Hamilton, Ontario, Canada