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# Does Quantitative Or Qualitative Data Lower Stigma Of Those Suffering From Schizophrenia?

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Does Quantitative or Qualitative Data Lower Stigma

of Those Suffering from Schizophrenia?

(TITLE)

BY

Fred A. Washburn

**THESIS**

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS  
FOR THE DEGREE OF

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IN THE GRADUATE SCHOOL, EASTERN ILLINOIS UNIVERSITY  
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**2011**

YEAR

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**Dedication Page**

I dedicate this thesis to my wife, Kristina. You had to sacrifice more than anyone so that I could get this done. You amaze me daily.

### **Acknowledgements**

I would like to acknowledge the support of Dr. Leitschuh, my thesis chair, for her help in getting this done. Even though she was on Sabbatical she was still able to help me through the troubled waters of the IRB. More important than her help with this thesis, I acknowledge her work in helping me become a tool for positive change.

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I acknowledge Dr. Larson for helping me to believe that I am capable enough to write a thesis. I guess we will find out.

### **Abstract**

This study examines social tolerance and support for legal coercion for people suffering from schizophrenia. Mental illness, defined as a biomedical illness, has decreased stigma and support for legal coercion for other mental illnesses but has the inverse relationship with schizophrenia (Phelan, Yang, Cruz-Rojas, 2006; Schnittker, 2008). This increase in stigma may be linked to scientific quantitative data that places the illness in control of the person. The study examines Eastern Illinois University students' (N=130) level of social tolerance and support for legal coercion for people suffering from schizophrenia after they have been exposed to qualitative data, quantitative data, or no data. The author discusses results and a possible historical link to stigma.

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## Chapter One: Introduction

### Purpose of the Study

Stigma towards those suffering from mental illness is well documented and has been recorded since the time of Socrates (Angermeyer & Matschinger, 2003; Finlay, Dinos, & Lyons, 2001; Jorm & Griffiths, 2008; Pilgrim, 2007; Read, Haslam, Sayce, & Davies, 2006). Stigma towards those suffering from a mental illness has been linked to greater difficulty finding work, housing, and friends (Read et al., 2006; Seeman, 2009), rejection by friends and family (Gonzalez-Torres, Oraa, Aristegui, Fernandez-Rivas & Guimon, 2007), internalized stigma (Finlay, Dinos, & Lyons, 2001), and lower treatment outcomes (Fung & Tsang, 2008; Lysaker, Salyers, Tsai, Spurrier, & Davis, 2008; Lauber, Carlos, & Wulf, 2005; Norman, Sorrentino, Windell, & Manchanda, 2008; Ulug, 2004). While all people suffering from mental illness deal with stigma, those suffering from schizophrenia deal with more stigma than any other mental illness (Graumgruber, Meise, Katschnig, Schony, & Fleischhacker, 2007; Phelan, Yang, Cruz-Rojas, 2006; Schnittker, 2008). Recent studies have shown that stigma for those suffering from depression, alcoholism, and bi-polar disorder have all decreased since 1990. However, those suffering from schizophrenia have had an increase of stigma since that time (Phelan, Yang, Cruz-Rojas, 2006; Schnittker, 2008). Because of the link between stigma, quality of life, and treatment, it is important for mental health professionals to not only understand the role of stigma in the lives of their clients but to actively seek to reduce that stigma (Norman et al., 2008; Harrison & Gill, 2009; Williams, 2008; Yanos, Lysaker, & Roe, 2010).

In order to understand both the role of stigma and how to lower stigma, mental health professionals must first understand the root of stigma for those suffering from schizophrenia. There are three main theories as to why stigma has increased among those suffering from schizophrenia; they are: the use of the bio-medical model and genetics to form an etiology for schizophrenia (Corrigan & Watson, 2004; Luchins, 2004; Jorm & Griffiths, 2008; Phelan, Yang, Cruz-Rojas, 2006; Read et al., 2006; Schnittker, 2008), the word schizophrenia (Boke, Aker, Aker, Sarisoy, & Sahin, 2007; Chung & Chan, 2004; Haraguchi, Maeda, Mei, & Uchimura, 2009), and the nature of diagnosing (Bentall & Pilgrim, 1993; Goffman, 1961; Laing, 1959; Pilgrim, 2007; Szasz, 1960). In this study the author will examine how a bio-medical model compared to a person-centered qualitative model will affect stigma of those suffering from schizophrenia.

### **Research Question and Hypotheses**

Will the use of person-centered qualitative data show a decrease in stigma, compared to bio-medical quantitative data and no data, at a small mid-western university?

There are three hypothesizes for this study. Hypothesis 1: Participants given qualitative data will be the most tolerant of those suffering from schizophrenia compared to the participants given quantitative. Hypothesis 2: Participants given qualitative data will be more tolerant of those suffering from schizophrenia than those who were not given any data (control group). Hypothesis 3: Participants given quantitative data will be more tolerant of those suffering from schizophrenia compared to those given no data at all (control group).

### **Significance of Study**

This study is significant as stigma is a growing concern, not only for those suffering from schizophrenia, but also for mental health professionals who strive to provide the best care for their clients. Although prior studies of stigma and anti-stigma campaigns for schizophrenia exist (Altindag, Yanik, Ucok, Alptekin, & Ozkan, 2006; Bell et al., 2010; Kukulcu & Ergun, 2007; Pinar & Fidanoglu, 2006; Rao et al., 2009; Sartorius, 2006), no prior studies using qualitative data to reduce stigma among students or in the general population could be located. If the author's hypothesis are supported, a new method to combat stigma would be available.

### **Limitations of Study**

There are limitations to this study; they include a small sample size (N= 130) and the paucity of a racially diverse sample. Another limitation is the inability to generalize results using a student population to the general population. There was a typo in some of the surveys that were distributed (see Appendix E). While this typo was minor it did cause at least one person to not complete the survey. The vignette used in the study depicts a specific type of schizophrenia (schizophrenia paranoid type, 295.30) and focuses on positive symptoms and not negative symptoms. While the vignette paints a good picture of someone suffering from schizophrenia it does not paint a complete picture. Lastly, as with all surveys, the survey used in this study cannot gather all information with regards to stigma, but only a small portion of what constitutes stigma.

### **Definition of Terms**

Schizophrenia in this study is defined in accordance with the Diagnostic and Statistics Manual IV- Text Revised (DSM) criteria for schizophrenia paranoid type. The DSM criteria are:

“295.30

#### Schizophrenia - Paranoid Type

A. *Characteristic symptoms*: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

(1) delusions

(2) hallucinations

(3) disorganized speech (e.g., frequent derailment or incoherence)

(4) grossly disorganized or catatonic behavior

(5) negative symptoms, i.e., affective flattening, alogia, or avolition

Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

B. *Social/occupational dysfunction*: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal

relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

*C. Duration:* Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

*D. Schizoaffective and Mood Disorder exclusion:* Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive, Manic, or Mixed Episodes have occurred concurrently with the active phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

*E. Substance/general medical condition exclusion:* The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

*F. Relationship to a Pervasive Developmental Disorder:* If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of

Schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

### **295.30 Paranoid Type**

A type of Schizophrenia in which the following criteria are met:

- A. Preoccupation with one or more delusions or frequent auditory hallucinations.
- B. None of the following is prominent: disorganized speech, disorganized or catatonic behavior, or flat or inappropriate affect (APA, 2000, p. 153-155)”

Person-centered qualitative data is defined as data that is qualitative and has the person suffering from the illness speaking about their illness; placing the importance of the person's perception of their illness over what experts think of the illness.

### **Summary**

Stigma has a negative effect on those suffering from mental illness, especially those suffering from schizophrenia (Angermeyer & Matschinger, 2003; Finlay, Dinos, & Lyons, 2001; Jorm & Griffiths, 2008; Pilgrim, 2007; Read, Haslam, Sayce, & Davies, 2006; Phelan, Yang, Cruz-Rojas, 2006; Schnittker, 2008). The ability to reduce stigma has a positive impact on those suffering from a mental illness (Norman et al., 2008; Harrison & Gill, 2009; Williams, 2008; Yanos, Lysaker, & Roe, 2010). There are three different theories as to the origin of stigma. No research exists using person-centered qualitative data as a means to reduce stigma.

## Chapter Two

### Literature Review

The controversies about diagnoses and stigma have been ongoing since the times of Socrates (Pilgrim, 2007). Socrates believed that madness held the same value of sanity and each had its own value. For instance, prophesying was considered a manic art. He believed that poetic inspiration and love both came from madness as he did not consider them to be logical in nature (Foucault, 1988). Most of ancient Rome and Greece did not see the world as Socrates did. They saw madness as something to be avoided and those who suffered from madness should be estranged from society (Simon, 1978).

This division on the understanding of 'madness' has led to different approaches to the etiology, treatment, and research surrounding mental illness. Much of today's research on mental illness is based on what was deemed a paradigm shift in etiology of mental illness, in 1980, that saw mental illness through a biomedical model (Lele, & Joglekar, 1998). This new biomedical model explained mental illness in terms of brain disorders (Torrey & Hafner, 1983). In 1984, Nancy Andreasen's book *The Broken Brain*, set the standard and gave direction to this new biomedical model. Andreasen's book promised to usher in a new era of hope due to the biomedical view on mental illness

(1984). Andreasen book has changed the way people view mental illness (Davidson, 2003).

While Andreasen's book did help bring prominence to the biomedical model of mental illness, it was not a new idea. A German psychiatrist in 1883, named Emil Kraepelin, saw mental illness through a similar lens as Andreasen. Kraepelin saw mental illness as a naturally occurring illness (biological) that was inherited (genetic), and the root of the illness was found in the brain or nervous system (Pilgrim, 2007). Kraepelin is known as the father of modern psychiatry, but his ideas were not new either. Hippocrates (ca 460 B.C. – ca 370 B.C.) was the first to view mental illness in terms of biology and thought that all mental illness began with a problem in the heart or diaphragm which he termed the *phren*. The word *phren* is considered to be the root for the English words: frenzy, frenetic, frantic, and schizophrenia (Pilgrim, 2007). Despite the work of Kraepelin and Hippocrates, it was not until the 1980s that the general public was willing to view mental illness as being a biomedical illness. This shift in public opinion may be linked to the work of Watson and Crick who, in 1952, discovered DNA. Their work helped all people see themselves in terms of genetics. The work of Watson and Crick gave the world 28 years to accept DNA and its impact on humans. While Andreasen's book did not cause a paradigm shift in the field of psychiatry, it did usher in a paradigm shift in the public's view of mental illness (Phelan, Link, Stueve, & Pescosolido, 2000).

Perhaps the most notable marker that the paradigm had shifted was in 1990. The United States Government in a combined effort with President George W. Bush, The Library of Congress, and the National Institute of Mental Health (NIMH) declared the 90's "The Decade of the Brain" (p 1). This new decade of mental health research was to



promote a more humane era in mental illness for those afflicted by the illness, their families, and all those working for a cure (Andreasen, 1984). These bright aspirations in mental health did not go unnoticed by the general public.

In 1996, a combined research effort between the University of Columbia and the University of Indiana was completed to examine how public opinions about mental illness had changed since 1950. The results of the public opinion study showed that the public definition of mental disorder had grown; the public was more willing to view mental illness in terms of a biological base and to recommend professional treatment to the mentally ill than they were in 1950 (Phelan, Link, Stueve, & Pescosolido, 2000). This new view of mental health among the public allowed for governmental steps to be made for the betterment of those with mental illness. In September of 2007, the Senate passed legislation that would require health insurance companies to provide the same level of coverage for mental health as they do for physical ailments. In March of 2008 the House approved the legislation (AP, 2008).

With new scientific understanding, more governmental help, and greater public understanding of mental illness, the biomedical model appeared to have ushered in the era of hope that Andreasen wrote about. However, with this greater understanding about mental illness there also came greater fear of those suffering from schizophrenia. The 1996 Phelan et al. study found that the public was two and a half times more likely to view someone with schizophrenia to be dangerous than the public did in 1950. A follow-up study by Schnittker, in 2006, looked at how public perception of mental health changed from 1996 to 2006. Schnittker's findings were consistent with the trends of the Phelan et al. study; the public in 2006 was more likely to see mental illness as a

biomedical illness, to recommend professional treatment and medication than in 1996. The public was also more likely to agree to laws that would force people afflicted with schizophrenia into treatment, see them as being dangerous to themselves and others, less likely to live next to (in terms of next door to and in the same neighborhood), work with, befriend, spend one evening socializing with, and marry into a family where someone suffers or suffered from schizophrenia (Schnittker, 2006). It appears that the biomedical model may have ushered in an era of enlightenment for an understanding of mental illness but sent the general population back in terms of stigmatizing those with schizophrenia. How can greater understanding of any disorder lead to greater intolerance for those afflicted? Where did the biomedical model fail in its attempts to usher in a new era of hope for those with mental illness? What follows are some possible explanations.

### **Biomedical Model, Popular Media, Availability Heuristic, and the Public**

The biomedical model has provided a great deal of information regarding different genes and chemicals that are related to the onset of schizophrenia. In its purest effort to find a cause and a cure it has left out the person, focusing solely on the disorder. In the three goals of genetic optimism there is no goal that focuses on the person with the disorder, rather, the goals focus on how the illness has control over the person afflicted. The goals also looked for an external force to cure the illness. The biomedical model focuses on an external locus of control, where those afflicted have no control over their illness in any aspect (Munetz, Geller & Frese, 2001). In response to the emphasis being put on the illness and not the person, the Mental Health Consumer/Survivor Movement has adopted the slogan: "Nothing about us without us" (Charlton, 1998, p3). This model

conveys the message "Do not talk about our illnesses without talking about us. We have some control in our treatment and recovery." (Davidson, 2003).

The biomedical model has left the person out of the illness; however, their absence in scientific research does not explain why the public is growing more stigmatized towards them. The question is, "Where is the public getting information about those afflicted with schizophrenia?" The most obvious answer is popular media. Popular media can be divided into two categories: news media and entertainment media. News media consists of newspapers, radio news, internet news, and television news programs. Entertainment media is any source of media that is not used for the purpose of gaining news or information.

A study done in Germany, by Angermeyer and Shulze (2001), on the largest German newspaper found that only 0.7% of articles in a nine month span made reference to the mentally ill. Such few articles may seem inconsequential, however, of the articles that did reference the mentally ill, 51% were about crimes someone with a mental illness had committed. Of the crime articles, 74% were violent crimes ranging from violent verbal abuse to cannibalism. The majority of news media on the mentally ill is dedicated to violent crimes that have been committed. How does this affect the general population? Thornton and Whal (1996) found that people who read news articles about violent crimes committed by someone with a mental illness will be more stigmatized, more fearful, and more socially restrictive of those suffering from a mental illness than a control group that did not read the same news article. From these findings, it is fair to say that news media does not present people with mental illness in a positive light and that these news articles help to form negative public opinion of the mentally ill.

Boke et al. (2007) viewed national and international newspapers (N=12) in Turkey and looked at the context for the word schizophrenia and its different conjugations. The study found that schizophrenia appeared every 2.2 days in at least one of the newspapers, with a positive reference occurring every 12.2 days and negative reference every 3.1 days. Of the negative references, 55.9% referred to the mental illness and 44.1% were used metaphorically. Of the metaphorical uses the majority were used to describe leftist and Islamic subgroups (87.6%). Only 8.1% of the political metaphors used to describe these groups did not include violent events. In Turkey, there is a correlation between schizophrenia and violence.

News media is not the only form of media that mis-portrays schizophrenia and those who suffer from it. Entertainment media is filled with people suffering from different kinds of mental illnesses. From Leonardo DiCaprio playing Howard Hughes and highlighting his obsessive compulsive disorder (OCD), to Jim Carey playing a schizophrenic in *Me, Myself and Irene*, to a bevy of other Hollywood misinterpretations of mental illness. Sadly, these are the public's main interactions with people who have serious mental disorders. These bad media representations of people with mental disorders, combined with the news media and the near silence of the scientific community about people suffering some mental illness, begin to paint the picture of why the public is more intolerant now than in the past.

The public opinions of the mentally ill are shaped by the media through a process called *availability heuristics*. Availability heuristics is a cognitive rule that places things in accordance to what is most available in memory, and places that that availability as the rule for which all like things are to be judged (Meyers, 2008). Look at what information

is readily available to the public on schizophrenia. The scientific community has implied that those with the disorder are subject to the illness despite any efforts they may make on their own. The media has portrayed those with schizophrenia as dangerous and uncontrollable. Using available heuristics, the public then views those with schizophrenia as being a dangerous threat to society who have no control over themselves and should not be dealt with by anyone but professionals. With this picture it is easy to see why the public is creating a greater social and emotional distance from people suffering from schizophrenia.

### **Where a public friendly qualitative method can help**

Allowing the person to share the spotlight with the disorder, in public friendly scientific journal articles, is one way that science can help the public overcome the fear of people suffering from schizophrenia. Having the media do a better job of realistically portraying mental illness would be another. But, as TV writer and obsessive compulsive disorder (OCD) sufferer Jonathan Solomon wrote in the Long Island newspaper *Newsday*: "Presenting OCD with complete accuracy would be quite dull. Everybody turns on and off light switches; we just do it over and over." (2000, p24). Thus the onus of allowing the person, not the illness, to be presented to the public in a truthful way lies with the scientist.

The first step in allowing schizophrenics to be presented to the public in a positive light would be to not let *anosognosia* scare the scientist. Anosognosia has long been associated with schizophrenia and is the inability of one suffering from schizophrenia to be aware that they have a mental disorder (Lele & Joglekar, 1998). It would appear that

allowing someone suffering from schizophrenia to take the spotlight may be more damaging than helpful, as this person may or may not know that they have a mental illness. Research (Bell, Bryson, Greig, Corcoran and Wexler, 2001; Green, Staz, Ganzell & Vaclav, 1992; Green, 1993, Jaeger & Dogulas, 1992; Liberman & Green 1992, Spring & Raven, 1992) takes the opposite stance; allowing people suffering from schizophrenia to have a larger role, not only with the public but also in helping to find a cure for their illness, is showing promising results. Social support in close family and friends is the strongest indicator in how to overcome anosognosia (White, Bebbington, Pearson, Johnson & Ellis, 2000). There is more that can be gained from allowing people suffering from schizophrenia to tell their story than what can be lost by keeping them quiet.

In a 1992 conference on schizophrenia, a woman suffering from schizophrenia took center stage and told how she was helping in her recovery by taking stock of herself.

These are her words:

“I have good will. It just takes the right amount of, the um, the kitchen has to be right, so to speak, before I... do the endeavors. The feeling... has to be right. Everything has to be right before you can make a cake... If you don't feel like buying flour for six months... then you don't feel like it. Then you go and get the flour, and then you notice that you don't have cinnamon, so you wait a while.”  
(Davidson & Strauss, 1992)<sup>1</sup>

After this woman spoke a well known professor came to Dr. Larry Davidson (the woman's doctor) and was amazed. The professor was unaware that someone suffering from schizophrenia could not only be so articulate but also take such a large role in her recovery (Davidson, 2003). It is also clear from this woman's comments that people suffering from schizophrenia can overcome their anosognosia and help paint a better,

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<sup>1</sup> Ellipses used to demonstrate pauses in speech.

truer picture of who they really are. Perhaps the best way for people to gain this social support is for their stories to be told. The best way to overcome anosognosia in schizophrenia is to not allow that anosognosia to stop people suffering from schizophrenia from telling their story.

### **Combining Biomedical Quantitative and Qualitative Methods**

With all the progress that has been made on the etiology of schizophrenia and medication for those suffering from schizophrenia, it would be foolish not to want to continue in that direction. That course should still go forward with some amendments. The three goals of genetic optimism should allow for greater empowerment by those afflicted with any disorder. Larry Davidson (2003), suggests nine different ways that a person with schizophrenia can take an active role in their treatment, recovery, and lives. They include: "Redefining self, Accepting illness, Overcoming stigma, Renewing hope and commitment, Resuming control and responsibility, Exercising citizenship, Managing symptoms, Being supported by others, and finally, being involved in meaningful activities and expanded social roles" (p 150-153). Redefining self and accepting illness would easily fit with genes have the potential to explain all mental illness. Once a person understands that the illness is not what they are, but rather a genetic combination that is no fault of their own, it would be easier to redefine who they are and accept their illness. As scientists search for the genes that cause all mental illness, those affected by the mental illness can search for ways to integrate themselves into society by exercising their citizenship, finding support in families, and being involved in meaningful activities that

would help to overcome the stigma of being a person suffering from schizophrenia. Those waiting for a cure can take control of their lives by managing their symptoms, having hope in who they are, and hope that someday a cure can be discovered.

## **Chapter Three**

### **Methodology**

#### **Design of Study**

This study was designed to quantitatively assess participants' social tolerance and support for legal coercion towards those suffering from schizophrenia as affected by quantitative data (see Appendix E), qualitative data (See Appendix F), or no data. Data came from different empirically approved articles on schizophrenia. The social tolerance and support for legal coercion scale was developed by Pescosolido et al. (1996) and tested at the General Social Survey (GSS) (N= 1800) and was found to be a reliable scale. The data were used to compare quantitative data to qualitative data and its effect on social tolerance and support for legal coercion.

#### **Participants**

Participants were selected from three departments at a mid-sized university. All participants were in the counseling (n= 22), kinesiology (n=67), or technology/engineering (n=22) departments. Participants were chosen due to their



enrollment in classes where professors had agreed to allow data collection either before or after class. Participants were given the informed consent (see Appendix C) and then were randomly assigned to either the control group or one of the two experimental groups. Participants completed the instruments, they were debriefed on the purpose of the study, and given an opportunity to ask questions.

There was a total of 130 participants in the study. Forty-seven participants were female, 69 were male, and 12 declined to identify their gender. Participants' ages ranged from 17 to over 40 years old, with the majority (70.7%) between the ages of 21-25. Ninety-two participants identified as Caucasian, 14 as African-American, 2 as Asian, 2 as Latino/Latina, and 20 participants declined to share their racial background.

### **Site**

A mid-sized public university was chosen for the site of this study. Participants volunteered from two graduate counseling classes, three kinesiology classes, and three technology/engineering classes. In the kinesiology and technology/engineering departments, participants included both undergraduate and graduate students.

### **Instrument**

One written case vignette, two different opinions about the case vignette and one scale was used in the study. The first instrument was a case vignette described someone suffering from schizophrenia (see Appendix C). The vignette was developed by Pescosolido et al. (1996) and used with permission. The importance of using a vignette in this study was to help disguise the mental illness and collect data based on symptoms

as opposed to a diagnosis. The vignette used was adapted so that the person being spoken of in the vignette would be considered to be a peer to the participants. All participants were exposed to the same vignette.

The social tolerance and support for legal coercion scale was also developed by Pescosolido et al. (1996) and tested at the GSS (N= 1800) and was found to be a reliable scale (Appendix G). The GSS is a nation-wide survey of opinion, attitudes and behaviors of the American Population. Considered the premier thermometer of the climate of American opinion, the GSS data is routinely used and GSS staff are regularly consulted by scholars, policy makers, and Congressional staff. Over 1,000 articles and reports have been published based on GSS data (Pescosolido et al., 1996). The scale is a seven point Likert scale. With one being definitely unwilling and seven being definitely willing. A score of four on the scale equals neither unwilling nor willing. All participants completed the social tolerance and support for legal coercion scale.

Two opinion pieces about the vignette were described by the author. One included the opinions regarding the vignette from a bio-medical perspective (Skleton, J. A., Pepe, M. A., & Pineo T. S., 1995; Hoffman, R. E., Varanko, M., Gilmore, J., & Mishara, A. L., 2008; and Lambert et al., 2008) (See Appendix E). The other opinion piece was developed from multiple articles from qualitative journals on schizophrenia (Gee, L., Pearce, E., & Jackson, M., 2003; Jenkins, J. H., & Carpenter-Song, E. 2006; and Davidson, L. 2003) (See Appendix F). The next two instruments were not given to every participant. The segments were chosen because they were empirically reviewed quantitative articles that treated the subject of schizophrenia. Information containing qualitative data (see Appendix F) was given to 46 participants. The qualitative segments

were taken from the following authors: Gee, L., Pearce, E., & Jackson, M., (2003); Jenkins, J. H., & Carpenter-Song, E. (2006); and Davidson, L. (2003). The Gee et al. (2003) and Jenkins & Carpenter-Song segments were from empirically reviewed qualitative journals, while the Davidson (2003) segment was taken from the book *Living Outside Mental Illness*.

### **Data Collection**

Data were collected after IRB approval of the study (Appendix A). The researcher contacted professors, both in person and via email. To obtain permission for participation in the study. The researcher collected data from cooperating instructors' students. All data was collected before or after class. Students who agreed to participate were given the informed consent (Appendix C) and the demographic form.

Participants were randomly assigned to the control group, qualitative or quantitative group. Cooperating participants were then randomly assigned to either the control group and were given the vignette (Appendix D), survey (Appendix G), and demographic questionnaire (Appendix H). The quantitative group packet consisted of the vignette (Appendix D), segments of quantitative data (Appendix E), the survey (Appendix G), and demographic questionnaire (Appendix H). The qualitative group packet consisted of the vignette (Appendix D), segments of qualitative data (Appendix F), the survey (Appendix G), and demographic questionnaire (Appendix H). After data was collected the researcher debriefed the participants of the intent of the study and thanked them for their participation.

### **Treatment of Data**

Informed consents were kept separate from surveys and demographic questionnaires to insure confidentiality. Informed consent forms and all data were stored in a cabinet behind a locked door in the counseling department library. Data from both the survey and demographic questionnaire were entered in Statistics Package for the Social Sciences (SPSS). The researcher ran a frequency analysis to gather demographic data: three independent t-tests (significance set at  $p < 0.01$ ) to test for differences between the groups (qualitative-quantitative, qualitative-control, and quantitative-control); if no differences were found at  $p < 0.01$ , the researcher ran the t-tests again at  $p < 0.05$ .

## **Chapter Four**

### **Results**

The data reported below were collected to determine if there were any significant differences in social tolerance and support for legal coercion based on type of information given to participants (no data, quantitative data, or qualitative data). Social tolerance and support for legal coercion were measured based on a scale developed by Pescosolido et al. (1996) and the GSS. The scale is used due to its face validity. A total of 150 students were eligible for the study, 135 were given the instruments, and 130 participated in the study.

## Descriptive Statistics

Table 1

### *Demographic Information*

Table 1 displays the population and proportion rate of the total number of participants (N=130) for the current study according to gender<sup>2</sup>, age, major, and race. The demographic results for each group can be found in Appendices I-K.

Demographic	N	Percent
Female	47	36.2
Male	69	53.1
Did not answer	14	10.8
17-20 years of age	18	13.5
25-30 years of age	7	5.4
30-35 years of age	1	.8
40+ years of age	4	3.1
Did not answer	14	10.8
Counseling student	22	16.9
Kinesiology/Sports Studies	67	51.5
Technology/Engineering	22	16.9
Did not answer	19	14.6

<sup>2</sup> Transgendered was an option, but no participants self-identified with that criteria.

Demographic	N	Percent
Caucasian	92	70.8
Latina/Latino	2	1.5
Asian	2	1.5
Did not answer	20	15.4

Table 2

*Know someone suffering from Schizophrenia*

Table 2 displays how many of the participants (N=130) know someone suffering from schizophrenia.

Yes	20	15.4
No	98	75.4
Answer	N	Percent
Did not answer	12	9.2



**Differences**

Table 3

*Hypothesis 1: Participants given qualitative data will be the most tolerant of those suffering from schizophrenia compared to the quantitative group.*

Table three shows that participants given qualitative data (n=46) were not significantly different than those given quantitative data in regards to social tolerance or support for social coercion using a two-tailed t-test (significance set at  $p < .05$ ).

	Quantitative		Qualitative		<i>t</i>	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Next Door	4.21	1.53	3.52	1.26	-1.31	0.23
Evening	4.62	1.32	4.11	1.61	-1.62	0.11
Friends	4.29	1.40	4.28	1.49	-0.01	0.99
Work With	3.98	1.51	3.65	1.39	-1.05	0.30
Group Home	4.69	1.87	4.24	1.84	-1.14	0.26
Marry	3.56	1.61	3.00	1.45	-1.83	0.07
Treatment	4.00	1.4	4.67	1.84	1.93	0.06
Medication	4.07	1.49	4.65	1.83	1.63	0.11
Hospital	4.02	1.47	4.11	1.52	0.37	0.80

Table 4

*Hypothesis 2: Students given qualitative data will be the most tolerant of those suffering from schizophrenia compared to the control group.*

Table four displays the mean, standard deviation, and *t* scores for participants in the control group (n=30) and the qualitative group (n=46). There were no significant differences between the groups using a two-tailed t-test (significance set at  $p < .05$ ).

	Control		Qualitative		<i>t</i>	<i>p</i>
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>		
Next Door	3.36	1.16	3.52	1.26	0.38	0.70
Evening	4.77	1.30	4.11	1.61	1.87	0.07
Friends	4.40	1.30	4.28	1.49	1.49	0.73
Work With	3.50	1.01	3.65	1.39	-0.52	0.61
Group Home	4.67	1.64	4.24	1.84	1.03	0.31
Marry	3.43	1.71	3.00	1.45	1.19	0.24
Treatment	4.13	1.76	4.67	1.84	-1.28	0.21
Medication	4.37	1.63	4.65	1.83	-0.69	0.49
Hospital	4.20	1.74	4.11	1.52	0.24	0.81

Table 5

*Hypothesis 3: Participants given quantitative data will be more tolerant of those suffering from schizophrenia than those given no data at all (control group).*

Table five displays the mean, standard deviation, and *t* scores for participants in the quantitative group (n=42) and the control group (n=30). There were significant differences between those willing to live next door to and those willing to work on a group project with someone suffering from schizophrenia, with participants in the quantitative group being more willing to do both ( $p < .05$ ). There were no other significant differences between the groups using a two-tailed t-test (significance set at  $p < .05$ ).

	Quantitative		Control		<i>t</i>	<i>p</i>
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>		
Next Door	4.21	1.54	3.63	1.16	-1.74	0.10
Evening	4.62	1.32	4.77	1.30	0.47	0.64
Friends	4.23	1.40	4.40	1.30	0.35	0.73
Work With	3.98	1.51	3.50	1.01	-1.51	0.14
Group Home	4.69	1.87	4.67	1.65	-0.56	0.96
Marry	3.56	1.61	4.43	1.71	-0.41	0.68
Treatment	4.00	1.40	4.13	1.76	0.36	0.72
Medication	4.07	1.49	4.37	1.63	0.80	0.43
Hospital	4.02	1.47	4.20	1.75	0.47	0.64

### Summary of Results

Results indicated that there were no significant differences between the qualitative and quantitative group and the qualitative and control group. Support for hypothesis one and two was not found. Results also indicated that there were two significant differences between the quantitative group and the control group. There were significant differences between those willing to live next door to and those willing to work on a group project with someone suffering from schizophrenia, with participants in the quantitative group being more willing to do both ( $p < .05$ ). Results partially supported hypothesis three.

Overall, results showed that social tolerance and support for legal coercion were not affected by qualitative data, quantitative data, or no data at all.

## Chapter Five

### Discussion/Recommendations/Conclusion

The purpose of this study was to examine the effect of different types of data (qualitative and quantitative) on social tolerance and support for legal coercion of those suffering from schizophrenia.

#### Discussion

Based on the results data type, qualitative or quantitative does not appear to increase or decrease social tolerance or support for legal coercion. This could mean that data available to the public may not be enough to sway public opinion of those suffering from schizophrenia. If data has no effect on social tolerance or support for legal coercion then the case for the bio-medical model of mental illness as the root for stigma appears to be less likely (Luchins, 2004; Jorm & Griffiths, 2008; Patrick & Watson, 2004; Phelan, Yang, Cruz-Rojas, 2006; Read et al., 2006; Schnittker, 2008). The fact that this type of data may not change opinions in regards to people suffering from schizophrenia is supported by Altindag et al. (2006); Ay, Save, & Fidanoglu (2006); and Rao et al. (2009), who studied the use of data based anti-stigma programs with medical students and had mixed results with stigmatized attitudes changing little over the course of six years of medical training.

The inability to use data to de-stigmatize people suffering from schizophrenia may be linked to the history of schizophrenia in Western Culture. The Greeks viewed madness (schizophrenic like symptoms) as a curse from gods or demons. The cure was

to see a skilled holy man who would either perform surgery (cut a hole in the person's head to let out evil spirits), give herbs and elixirs that were mainly sedative in nature, or say magic words that would cast out the demons (Porter, 2002). Lobotomies were used to treat schizophrenia into the 1900s, medications today are sedative based, and therapy could be considered as seeing someone who will say magic words to help the person get better. If our treatment ideas have not improved over thousands of years, then it would make sense that stigma would not have improved much either.

A second historical link can be drawn to the treatment of those who suffer from schizophrenia. Historically, people with madness were either taken care of by family or cast out of society (Porter, 2002). Today we allow family members to also care for their relatives who suffer from schizophrenia or we place them in group homes. Foucault (1988) notes that group homes were originally developed to stop the spread of leprosy. When leprosy was eliminated from society the group homes did not close but were used to house people suffering from madness. The rationale for their removal was in hopes that madness, like leprosy, would go away. While group home for madness' idea may have made sense five hundred years ago, today, however, it is no longer useful.

An interesting component of this study was to examine participants across their fields of study to examine if degree choice among participants would cause a difference in stigmatizing attitudes. The researcher found that students in counseling<sup>3</sup> (n= 22) were more in support of living next door to, spending an evening with, being friends with, working on a project with, and having someone marry into their family who suffers from

---

<sup>3</sup> All counseling students in the study had taken or were currently taking the diagnostics class.

schizophrenia (significance set at  $p < 0.05$ ) when compared to kinesiology students ( $n=67$ ) (Appendix L). However, there were no differences in building a group home for people suffering from schizophrenia or supporting laws that would force people suffering from schizophrenia to receive treatment, take medication, and stay in a hospital against their will. These results may be skewed due to the imbalance in sample size between the two groups. When counseling students ( $n=22$ ) were compared to technology/engineering students ( $n= 22$ ) the differences were less. Counseling students were more in support of living next door to and having someone marry into their family that suffers from schizophrenia, but there were no other differences between the groups (Appendix M). These results indicate that counseling students may be more likely to support social tolerance but they are just as likely to support legal coercion for people suffering from schizophrenia. These mixed results were consistent with studies on medical students who also received training on mental health issues (Altindag et al. (2006); Ay, Save, & Fidanoglu (2006); Rao et al. (2009). To lower stigma against those suffering from schizophrenia it would appear that something other than education is needed.

Boke et al. (2007); Chung & Chan (2004); Haraguchi, Maeda, Mei, & Uchimura, (2009), have all argued that the word schizophrenia was the root of stigma. Bentall & Pilgrim (1993), Goffman (1961), Laing (1959), Pilgrim (2007), and Szasz (1960) have all argued that the nature of diagnosing leads to stigma for those suffering from schizophrenia. This study attempted to remove both of those variables by not exposing participants to the word schizophrenia until after they had completed the scales for social tolerance and support for legal coercion; removing both the word and the diagnosis that comes with the word. The participants were only exposed to the symptoms of someone

suffering from schizophrenia. Despite the removal of these variables, stigma was still found across all groups. This indicates that people suffering from schizophrenia may be stigmatized due to the unique and unfamiliar positive symptoms that occur in the illness and were highlighted in the vignette. In other mental illness, people may be able to better relate to the symptoms of the illness compared to the symptoms of schizophrenia.

### **Recommendations from Results of the Present Study**

The following suggestions for students in counseling, counselor in practice, and professors of counseling are based on the findings of this study.

1. Understanding the role of stigma on both a general level and a personal level. It appears that students in counseling hold a level of stigma to those who may be their future clients. It is important for students to understand how stigma may impact their ability to work effectively with clients.

2. Counselors in practice should check themselves to make sure that they are empowering their clients and not disempowering them due to their illness.

3. It may be beneficial for professors to be aware that some of their students may not be ready to work with clients suffering from schizophrenia as they may hold stigmatized beliefs about those clients. It may also be beneficial to examine the negative impact of stigmatization of people suffering from mental illness in the diagnostic class.

### **Recommendation for Future Research**

The following recommendations for future research are based on the findings of this study.



1. An in depth study that examines only counseling students and their feelings towards those suffering different types of mental illness.

2. A study that looks at only the symptoms of a mental illness without asking about diagnoses that examines social tolerance and support for legal coercion solely based on various symptoms.

3. A study that examines counselor's personal beliefs towards people suffering with schizophrenia and their effectiveness in working with those clients.

### **Conclusion**

The purpose of this study was to examine social tolerance and support for legal coercion for someone suffering from schizophrenia based on qualitative data, quantitative data, and no data. While the results showed that the type of data had little influence on social tolerance and no influence on support of legal coercion, the author believes that the public will need more information on schizophrenia to change attitudes.

The type of data given to participants may not have been enough to stem the tide of information that has been passed down for centuries on the dangers of schizophrenia. On a larger scale, this study looked at human interactions and human hierarchy. Much like skin color, sexual orientation, and religion, mental illness is an excuse for some to remove power from others and isolate them. While there have been many different anti-stigma programs for many inequalities, it may be that social tolerance, like empathy, cannot be taught, it can only be experienced.

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## Appendix A

Fred Washburn

Counseling and Student Development

Thank you for submitting the research protocol titled, "Who is in Control, the Illness or the Person? Qualitative and Quantitative Views on Schizophrenia" for review by the Eastern Illinois University Institutional Review Board (IRB). The IRB has approved this research protocol following an expedited review procedure. IRB review has determined that the protocol involves no more than minimal risk to subjects and satisfies all of the criteria for approval of research.

This protocol has been given the IRB number 10-109. You may proceed with this study from 10/7/2010 to 10/6/2011. You must submit Form E, Continuation Request, to the IRB by 9/6/2011 if you wish to continue the project beyond the approval expiration date.

This approval is valid only for the research activities, timeline, and subjects described in the above named protocol. IRB policy requires that any changes to this protocol be reported to, and approved by, the IRB before being implemented. You are also required to inform the IRB immediately of any problems encountered that could adversely affect the health or welfare of the subjects in this study. Please contact me, or the Compliance Coordinator at 581-8576, in the event of an emergency. All correspondence should be sent to:

Institutional Review Board

c/o Office of Research and Sponsored Programs

Telephone: 581-8576

Fax: 217-581-7181

Email: [eiuirb@www.eiu.edu](mailto:eiuirb@www.eiu.edu)

Upon completion of your research project, please submit Form G, Completion of Research Activities, to the IRB, c/o the Office of Research and Sponsored Programs.

Thank you for your assistance, and the best of success with your research.

Robert Chesnut, Chairperson

Institutional Review Board

Telephone: 581-2125

Email: [rwchesnut@eiu.edu](mailto:rwchesnut@eiu.edu)

Appendix B

## Approval of Thesis Proposal

Name Fred A. Washburn

SS#/Banner ID EIU #: E12333920

Title of Thesis

Who is in Control: The Illness or the Person? Qualitative and Quantitative Views

Schizophrenia

The thesis project is to be conducted in the manner described in the proposal with the following exception and/or conditions:

Demographics

3 Hypotheses

Editing

Contact authors of vignette and scale for permission

14 April 2010

Date of Approval

Gloria A. Zetsch  
Chairperson, Thesis Committee

Angela M. Gale, Ph.D.  
Member, Thesis Committee

Howard R. Cam, Ph.D.  
Member, Thesis Committee

## Appendix C

**Consent Form**

**Introduction:** This research is being conducted by Fred Washburn, in the counseling department at Eastern Illinois University under the supervision of Dr. Gloria Leitschuh to examine the attitudes of EIU students regarding John and people like him.

**Procedures:** You will be asked to read a vignette of 177 words and then complete a questionnaire consisting of 10 questions about John. It will take you between 5 and 15 minutes to finish. The questionnaires will also ask you for basic demographic information (age, gender, ethnicity, etc.).

**Risks/Discomforts:** There are minimal risks for participation. You may feel some emotional discomfort when reading about and answering questions regarding your attitudes towards John.

**Benefits:** You may gain an increased awareness of people like John.

**Confidentiality:** All data will be kept in a locked cabinet in the counseling department offices. All information provided will remain confidential and will only be reported as group data with no identifying information. Data will be shredded after the study has concluded.

**Compensation:** There is no compensation.

**Participation:** Participation in this research study is voluntary. You have the right to withdraw at anytime or refuse to participate entirely.

**Questions about the Research:** If you have questions regarding this study you may contact Fred Washburn via email [fawashburn@eiu.edu](mailto:fawashburn@eiu.edu).

**Questions about your Rights as Research Participants:**

If you have questions you do not feel comfortable asking the researcher, you may contact Dr. Gloria Leitschuh via email at [gleitschuh@eiu.edu](mailto:gleitschuh@eiu.edu). Or the IRB office you may call or write: Institutional Review Board, Eastern Illinois University, 600 Lincoln Ave., Charleston, IL 61920, Telephone: (217) 581-8576, E-mail: [eiuirb@www.eiu.edu](mailto:eiuirb@www.eiu.edu)

I have read and understood the above consent and desire of my own free will and volition to participate in this study.

Signature: \_\_\_\_\_

Date:

\_\_\_\_\_

## Appendix D

### Some information about John

John is a white man currently enrolled in college. Up until a year ago, life was pretty okay for John. But then, things started to change. He thought that people around him were making disapproving comments and talking behind his back. John was convinced that people were spying on him and that they could hear what he was thinking. John lost his drive to participate in his usual school work and activities. He started retreating to his home, eventually spending most of his days in his room. John was hearing voices even though no one else was around. These voices told him what to do and what to think. He has been living this way for six months.<sup>4</sup>

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<sup>4</sup> Reprinted with author's permission: Pescosolido, B. A., Martin, J. K., Link, B. G., Kikuzawa, S., Burgos, G., Swindle, R., & Phelan, J. (1996). American's view of mental health and illness at century's end: continuity and change. *Public Report on the MacArthur Mental Health Module, 1996 General Social Survey*.

## Appendix E

### What experts say about people like John

67% of patients scored above the median on psychiatrists' ratings of symptom remission following treatment with clozapine, compared with about 33% of patients following treatment with other antipsychotic medications; about 65% of clozapine-treated patients scored above the median on psychiatrist-rated improvement scales, compared with about 35% of patients treated with other drugs.<sup>5</sup>

Most patients like John and persistent Audio Visual Hallucinations (AVHs) clearly distinguish these experiences from their everyday thoughts. An adequate mechanistic model of AVHs should account for distinctive content, recognizable non-self speaking *voices*, and diminished sense of control relative to ordinary thought. Loudness and clarity of sound images appear to be of secondary importance in demarcating these hallucination experiences.<sup>6</sup>

With respect to functional outcome, 45% of subjects were in 6-month functional remission at endpoint and approximately a third achieved functional recovery. As nearly 60% of subjects were employed, 70% were living independently, and about 80% had regular social contacts, the biggest obstacle was the simultaneous achievement of all three functional remission components. The most relevant predictors of functional remission comprised the functioning level at baseline in all three domains, early functional remission at 3-month, and younger age. Thereby, the present study confirms that patients level of functioning at entry is a reliable predictor of later level of function and overall outcome.<sup>7</sup>

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<sup>5</sup> Segment from Skleton, J. A., Pepe, M. A., & Pineo T. S., (1995). How much better is Clozapine? A meta-analytic review and critical appraisal. *Experimental and Clinical Psychopharmacology*, 3, 270-279.

<sup>6</sup> Segment from Hoffman, R. E., Varanko, M., Gilmore, J., & Mishara, A. L., (2008). Experiential features used by patients with schizophrenia to differentiate 'voices' from ordinary verbal thoughts. *Psychological Medicine*, 38, 1167-1176.

<sup>7</sup> Segment from Lambert et al., (2008). Rates and predictions for remission and recovery during 3 years in 392 never-treated patients with schizophrenia. *Acta Psychiatrica Scandinavica*, 118, 220-229.

## Appendix F

### What people like John say about themselves

"There's sort of voices and all sorts of mayhem going on inside and there's not enough of your brain left to concentrate on what people are saying. You're sort of dealing with all of this."

"They [voices] have affected me quite a lot. They've made me try to harm myself and do things like that, that I don't want to do. I didn't feel that I could talk to people about these things because of what they may think. I felt that I had a problem that I had to deal with on my own. Yes, I felt like that..... on my own."<sup>8</sup>

I think it's under control now because of the medication. I think it's part of the Clozaril—I wasn't able to control it, even if I wanted to I couldn't. And uh . . . I think the most important thing is finding the right medication that starts to interact with the illness. And it just takes a long time. You know, you have to be willing to invest the time, you know, taking medications and waiting for it to . . . 'cause you can try—I mean I was on a number of medications, and they didn't do anything for me. So it's—I think the first thing is trying to find the right medication, and then that can take a long time. It took a long time for me.<sup>9</sup>

I have good will. It just takes the right amount of, the um, the kitchen has to be right, so to speak, before I... do the endeavors. The feeling... has to be right. Everything has to be right before you can make a cake... If you don't feel like buying flour for six months... then you don't feel like it. Then you go and get the flour, and then you notice that you don't have cinnamon, so you wait a while."<sup>10</sup>

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<sup>8</sup> Segment from Gee, L., Pearce, E., & Jackson, M., (2003). Quality of life in schizophrenia: A grounded theory approach. *Health and Quality of Life Outcomes*, 1, 70-81.

<sup>9</sup> Segment from Jenkins, J. H., & Carpenter-Song, E. (2006) The new paradigm of recovery from schizophrenia: Cultural conundrums of improvement without care. *Culture, Medicine and Psychiatry*, 29, 379-413.

<sup>10</sup> Segment from Davidson, L. (2003) *Living Outside Mental Illness*. New York: New York University Press.

### Appendix G

Please answer the following questions based on this scale: 1- definitely unwilling, 2- unwilling, 3- slightly unwilling, 4- neither unwilling nor willing, 5 slightly willing, 6 willing, 7- definitely willing.

1. How willing would you be to have John move next door to you?

1      2      3      4      5      6      7

2. How willing would you be to spend an evening socializing with John?

1      2      3      4      5      6      7

3. How willing would you be to make friends with John?

1      2      3      4      5      6      7

4. How willing would you be to have John start working closely with you on a group project?

1      2      3      4      5      6      7

5. How willing would you be to have a group home for people like John open in your neighborhood?

1      2      3      4      5      6      7

6. How willing would you be to have John marry into your family?

1   2   3      4      5      6      7

7. How willing would you be to force John by law to get treatment at a clinic or by a doctor?

1   2   3      4      5      6      7

8. How willing would you be to force John by law to take prescription medication to control his behavior?

1   2   3      4      5      6      7

9. How willing would you be to force John by law to be admitted to a hospital for treatment?

1      2      3      4      5      6      7<sup>11</sup>

10. Do you know anyone that suffers from Schizophrenia? Yes/No

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<sup>11</sup> Reprinted with author's permission: Pescosolido, B. A., Martin, J. K., Link, B. G., Kikuzawa, S., Burgos, G., Swindle, R., & Phelan, J. (1996). American's view of mental health and illness at century's end: continuity and change. *Public Report on the MacArthur Mental Health Module, 1996 General Social Survey.*



Appendix H  
Demographics Questions

What is your Gender?

1. Female      2. Male      3. Transgendered

What is your age?

1. 17-20      2. 21-25      4. 25-30      5. 30-35      6. 35-40      7. 40+

What is your Major or Degree (please write in)?

What year in school are you?

1. Freshman      2. Sophomore      3. Junior      4. Senior      5. Graduate  
6. Not a student

How do you racially identify (Please write in)?

Appendix I  
Control Group

Demographic	N	Percent
Female	5	13.3
Male	24	80.0
Did not answer	1	3.3
17-20 years of age	3	10
21-25 years of age	8	26.7
25-30 years of age	5	16.7
30-35 years of age	2	6.9
40+ years of age	0	0
Did not answer	1	3.3
Counseling student	3	10
Kinesiology/Sports Studies student	13	43.3
Technology/Engineering student	11	36.7
Did not answer	3	10.0
Caucasian	26	86.7
African American	0	0
Latina/Latino	1	3.3
Asian	0	0
Did not answer	3	10

Appendix J

Quantitative Data Group

Demographic	N	Percent
Female	25	59.5
Male	17	40.5
Did not answer	0	0
17-20 years of age	2	4.8
21-25 years of age	29	69.0
25-30 years of age	0	0
30-35 years of age	5	11.9
40+ years of age	6	14.2
Did not answer	0	0
Counseling student	19	45.2
Kinesiology/Sports Studies student	22	52.4
Technology/Engineering student	0	0
Did not answer	1	2.4
Caucasian	35	83.3
African American	5	11.9
Latina/Latino	1	2.4
Asian	1	2.4
Did not answer	0	0

Appendix K  
Qualitative Group

Demographic	N	Percent
Female	3	6.5
Male	43	93.5
Did not answer	0	0
17-20 years of age	2	4.3
21-25 years of age	1	2.2
25-30 years of age	15	32.6
30-35 years of age	26	56.5
40+ years of age	1	2.2
Did not answer	1	2.2
Counseling student	0	0
Kinesiology/Sports Studies student	32	69.7
Technology/Engineering student	11	23.9
Did not answer	3	6.5
Caucasian	31	67.4
African American	9	19.6
Latina/Latino	1	2.2
Asian	0	0
Did not answer	1	2.2

Appendix L

	Counseling		Kinesiology		<i>t</i>	<i>p</i>
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>		
Next Door	4.68	1.39	3.64	1.26	3.27	0.02
Evening	5.14	0.94	4.14	1.57	2.78	.007
Friends	4.82	1.26	4.03	1.56	2.15	0.03
Work With	4.28	1.45	3.55	1.36	2.12	0.04
Group Home	5.18	1.79	4.42	1.89	1.66	0.10
Marry	4.28	1.79	3.06	1.53	3.12	0.02
Treatment	3.82	1.37	4.45	1.65	-1.61	0.11
Medication	3.86	1.55	4.46	1.67	-1.48	0.14
Hospital	1.73	1.55	4.15	1.44	-1.62	0.32

Appendix M

	Counseling		Technology/Engineering		<i>t</i>	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Next Door	4.68	1.39	3.64	1.18	2.67	0.02
Evening	5.14	0.94	4.45	1.34	1.96	0.06
Friends	4.82	1.45	3.73	0.90	0.55	0.56
Work With	4.27	1.45	3.73	0.88	1.50	0.14
Group Home	5.18	1.79	4.36	1.40	1.69	0.10
Marry	4.27	1.75	3.05	1.36	2.60	0.02
Treatment	3.82	1.37	4.18	1.89	-0.73	0.47
Medication	3.86	1.55	4.32	1.76	-0.91	0.37
Hospital	4.73	1.55	4.23	1.69	-1.02	0.32