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Effects of Perceived Religiosity on Judgments of Social Competence Toward Individuals With Mental Illness

This study examined mental illness stigma and its relationships to 1) type of mental disorder and 2) the social involvement of those with mental illness. Fifty college subjects were asked to read vignettes describing a character who had either schizophrenia or depression, and who was depicted as either active in their church, active in the community, or whose activities were not mentioned. Perceptions of the characters' social competence were measured using a Judgment of Social Competence Questionnaire. Results demonstrated a significant effect for type of social involvement on judgment of social competence, but no such effect for type of mental disorder. Due to the occurrence of the Virginia Tech Massacre in the middle of the study, the effect of this event on stigmatizing attitudes was also examined.

In recent years, the stigma of mental illness has been increasingly recognized by the public, and people's understanding of mental illness has been improving (Link & Phelan, 1999). However, stereotypes of dangerousness and the desire for social distance towards the mentally ill persist (Link and Phelan, 1999). Previous studies and surveys indicate that individuals with mental illness report stigmatization by families, communities, and churches, as well as mental health service providers and agencies (Campbell & Schraiber, 1989; Wahl, 1999). In a survey of people with psychiatric disabilities, Campbell and Schraiber (1989) found that 52% of participants indicated they had been discriminated against because they received mental health services. Also, 41% indicated that others treated them differently all or most of the time after becoming aware of their psychiatric diagnosis or treatment status. Negative public attitudes, stereotypes, and misconceptions can severely impede the psychological well-being of those with mental illness by adding extra emotional burdens of anger, hurt and degradation, as well as hindering their quality of life and treatment outcome (Link & Phelan, 1999; Nolan, 2000).

Three theoretical models have been identified to explain mental illness stigma: socio-cultural perspectives (i.e., stigmatizing attitudes develop to justify existing community injustices), motivational biases (stigmatizing attitudes develop to meet basic psychological need) and social cognitive theories (stigmatizing attitudes are understood as knowledge structures that develop from community experience) (Corrigan, 1998). Of these three, social cognitive theories are believed to offer the best theoretical support. One example of a social cognitive model is attribution theory, which examines causes of the mental disorder as perceived by the public (Corrigan et al., 2000).

Further, we know that mental illness has a diverse spectrum of types, severity and symptoms. Thus, it is important to know whether the public differentially stigmatizes psychiatric disorders according to the characteristics of the illness and perceptions of illness-causing factors. Corrigan et al. (2000) found that certain mental disorders are perceived as more self-attributed, less worthy of pity, more dangerous and worse prog-

nostically than others. For example, schizophrenia is viewed more negatively and has a higher stigmatized label than depression (Corrigan et al., 2000). The purpose of the present study is to further examine how the public differentially stigmatizes disabilities within the psychiatric spectrum by specifically looking at schizophrenia (a highly stigmatized disorder) and depression (a lowly stigmatized disorder). In addition, we explored whether the perception of religious support for the people with mental illness would have an impact on stigmatizing attitudes.

The relationship between religion and mental health has been of continued interest in both psychology and psychiatry. Previous studies have tried to examine the possible link between religion and mental illness; however, the results are often mixed and contradictory (Lewis, 2001). Some studies have shown a positive relationship between religiosity and mental-health (Chamberlain & Zika, 1992, as cited in Lewis, 2001), some have shown a negative relationship (Batson & Venntis, 1982, as cited in Lewis, 2001), while others have shown almost no relationship (Bergin, 1983, as cited in Lewis, 2001). For example, in Chamberlain & Zika's study (as cited in Lewis, 2001), religion is considered as having a healing effect that positively influences psychological well-being through giving a sense of meaning in life. However, other evidence suggests that religion fosters poorer mental health in terms of promoting obsession and rigidity (Yossifova & Lewenthal, 1999). Despite the overall ambiguity, there does seem to be a cultural stereotype in regards to religion and mental health (Lewis, 2001). The present study aimed to examine whether the religiosity of someone with mental illness, represented by religious social involvements, affected attitudes regarding the social competence of the person being judged.

According to Hayward and Bright (1997), disruption of social interaction is considered to be one of the four possible root causes of people's stigmatizing views towards the mentally ill. Many people perceive individuals who suffer from mental illness as not fitting into normal patterns of social interaction and not following accepted social rules (Hayward & Bright, 1997). People often feel uneasy interacting with individuals with mental illness. This uneasiness may in part stem from their own preconceived stereotype that individuals with a mental illness have poor social skills. Thus, in this study, we used a questionnaire to assess perceptions of social competence in order to indirectly measure people's stigmatizing attitudes towards the mentally ill. This objective approach was expected to minimize demand characteristics and effects of social desirability among subjects.

According to the Corrigan et al. (2000) study using attribution theory, people with schizophrenia are more negatively stigmatized than those with depression. In addition to manipulating the variable of religious involvement, the vignettes described someone with either schizophrenia or depression. Specifically, three hypotheses were proposed. First, we hypothesized that a person with schizophrenia (a highly stigmatized mental disorder) would be viewed as less socially competent than a person with depression (a lowly stigmatized mental disorder). Second, it was hypothesized that individuals with mental illness would be perceived as being more socially competent if they engaged in religious activities (church involvement) compared to individuals who engaged in either non-religious activities (community involvement) or whose social involvements were not mentioned. Lastly, we hypothesized that religious involvement would have a larger impact on perceived social competence of a person with depression than on the individual diagnosed with schizophrenia.

Method

Participants

Fifty undergraduate students at a private faith-based university in the Southeast volunteered for this study in order to earn extra credit in one of several social science classes. All participants were 19 years of age or older. There were 42 female participants, and 8 male participants. All of the 50 students who participated in the study completed the measure.

Material

Participants were given a packet containing one of six vignettes and a Judgment of Social Competence Questionnaire. Each vignette described one character who was diagnosed with either schizophrenia or depression. Depending on the specific diagnosis, the DSM-IV definition of either schizophrenia or depression was given preceding each vignette. Each character's social involvement (i.e., religious, community, or none) was also described. For example, the character who engaged in religious activities was described as "attending Sunday school and worship services every Sunday, joining Bible classes in church every Wednesday night, praying daily and engaging very actively in a variety of other church fellowships and services." The character who engaged in non-religious community activities was described as "going to the local community center every Sunday to watch movies and have discussions, taking a public health class every Wednesday night, journaling daily about their everyday lives and engaging very actively in a variety of other community activities and services." No social activities were mentioned for the character in the control group. Thus, this 2 X 3 (mental illness X social involvement) factorial design

produced six conditions: schizophrenia with religious activity (S/R) (*n*=9), schizophrenia with community activity (S/C) (*n*=8), schizophrenia with no mentions of activities (S/N) (n=8), depression with religious activity (D/R) (*n*=9), depression with community activity (D/C) (*n*=8), and depression with no mentions of activities (D/N) (*N*=8).

The Judgment of Social Competence Questionnaire was designed by the experimenters to assess participants' perceptions of social skills for the character in each vignette. This questionnaire served as an indirect approach to measure participants' stigmatizing attitudes towards the mentally ill. It consisted of fourteen questions related to tasks of social functioning. Participants were asked to rate how likely the character was able to fulfill these tasks on a 5-point Likert scale (1=not at all likely, 5=definitely). In addition, all questions were purposefully phrased in third person to minimize social desirability and demand characteristics among the subjects. Typical items included "How likely is it that C.R. will approach others positively?" and "How likely is it that C.R. would be able to share and discuss ideas comfortably in front of other people?"

A demographic survey was also used to assess subjects' gender, age, class, major, religious belief, and their opinions about mental illness stigma. They were also asked about their perception of the characters' religiosity in the vignette. These answers served as a manipulation check for the experiment.

Procedure

In order to minimize the possibility of demand characteristics, on the sign-up sheets used to recruit participants, the study was titled "Mental Illness and Social Involvement." Packets containing one vignette and a Judgment of Social Competence Questionnaire were randomly distributed to participants. Participants were asked to read the vignette carefully and then to complete the questionnaire. After turning in the packets, participants were asked to complete a demographic survey. Finally, participants received their extra credit form, were fully debriefed, and thanked for their participation.

Results

Preliminary Analysis

Prior to testing our hypotheses, we first examined the internal consistency of the items in the Judgment of Social Competence Questionnaire. A mean Cronbach's alpha coefficient of .89, across the six conditions, indicated of the questionnaire was .89 across the 6 conditions, demonstrating high inter-item reliability. Thus, we were able to use the sum total of the item scores in the questionnaire as a single dependent variable in sta-

tistic analysis. Not including three filler questions, there were a total of eleven questions used in the statistical analysis with a maximum possible score of 55.

In order to determine whether our manipulation of religiosity was successful, we examined the ratings of one particular question in the demographic survey - "How religious do you perceive the character in the vignette to be (1- not at all religious, 5 – highly religious)?" One-way ANOVA compared the mean ratings of this question among the three types of social involvement conditions (religious vs. community vs. none). As expected, there was a significant difference for this variable, $F(2, 47) = 16.768$, $p < .01$, and Tukey post hoc analysis revealed that characters who engaged in church activities ($M = 4.11$, $SD = .47$) were rated significantly higher in religiosity than characters who engaged in community activities ($M = 3.19$, $SD = .75$, $p < 0.01$), and significantly higher than those whose activities were not mentioned ($M = 2.75$, $SD = .86$, $p < 0.01$). No significant difference was found between the community condition and the no-mention condition ($p = 0.085$). These statistics indicate successful manipulation of the level of religiosity.

Analysis

A two-way ANOVA was conducted to analyze this 2 X 3 (mental illness X religiosity) factorial design. Contrary to our hypothesis, no significant difference in perceived social competence was found between characters who had schizophrenia ($M = 36.92$, $SD = 7.95$) and those

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FIGURE 1

Mean ratings of perceived social competence for characters who were diagnosed with depression (*n* = 25) and characters who were diagnosed with schizophrenia (*n* = 25).

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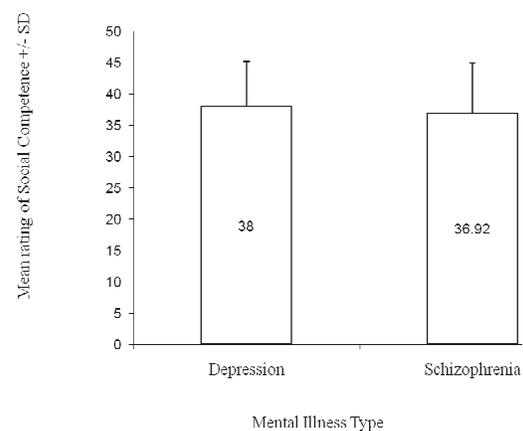
with depression ($M = 37.94$, $SD = 7.18$), $F(1, 48) = .325$, $p = .572$ (see Figure 1).

A significant difference in perceived social competence was found among the three types of social involvement, $F(2, 47) = 8.279$, $p = 0.001$ (see Figure 2). Tukey post hoc analysis revealed a significantly higher perception of social competence for the church involvement condition ($p = 0.01$) and the community involvement condition compared to the no-mention condition ($p < 0.01$); however, no significant difference was found between church and community involvement conditions ($p = 0.16$). Also, contrary to our hypothesis, no significant interaction was found in social competence ratings between types of mental illness and type of social involvement, $F(2, 47) = .272$, $p = .763$.

Discussion

Contrary to prior research (Corrigon, et al., 2000), only one of the hypotheses for this experiment was supported. A highly stigmatized mental illness did not produce a more negative perception about a character' social functioning; a lowly stigmatized disorder did not add any favor to such perception. One possible explanation could be that the sample for this study shared a fairly specific and homogeneous background, i.e., all participants were college students who might have been exposed to educational information and learning materials related to mental disorders. These

FIGURE 2

Comparison of mean ratings of perceived social competence across three types of social involvement conditions: church involvement ($M = 38.39$, $SD = 7.59$, n = 18), community involvement ($M = 41.69$, $SD = 4.94$, n = 16), and no-mention condition ($M = 32.19$, $p = 6.73$, n = 16).


experiences could have provided them with a better understanding of and a more objective view towards different types of mental illness. Previous research has suggested that persons with a higher educational level and social class view the mentally ill more favorably (Link & Cullen, 1986). Furthermore, age can also be a factor in shaping attitudes toward the mentally ill. Previous studies have found that younger people tend to be more tolerant of the mentally ill than older people (Brockington, Hall, Levings & Murphy, 1993; Parra, 1985). As a result, our young participants, aged 18 to 22 years old, might have less negative attitudes toward people with severe mental disorder, such as schizophrenia, than older people in the public.

Similar perceptions toward people with depression and schizophrenia, as observed in this study, could suggest a change, across time, in the nature of stigma driven attitudes. Whereas "old-fashioned" prejudice may have been more blatant and hostile, efforts at eliminating stigma, while not totally successful, may have produced a new form of prejudice that are more subtle and ambivalent. For example, Chugh (2004) pointed out that "the discriminator aspires to and believes in a self-image that is non-discriminating, yet [s/he] does discriminate in certain situations" (p. 207). In order to investigate this possibility, it would be useful to use implicit, rather than explicit, measures to assess possible unconscious prejudice, or stigma, towards people with diverse forms of mental illness.

Even though there was a significant main effect for different types of social involvement, no significant difference in perceived social competence was found between characters who engaged in church activities and those involved in community activities. In terms of the mean ratings, characters who engaged in community activities were actually rated the highest on perceived social functioning. This finding is contrary to our original prediction that religious involvement would induce more favorable views on social competence of the mentally ill. One possible explanation might be the lack of specific descriptions of characters' religious beliefs in the vignettes. In the vignettes, we only used the church activities that characters attend to imply their levels of religiosity. Even though the manipulation of religiosity appeared to be successful, more detailed and subjective information about characters' religious beliefs might have led to support of the hypothesis regarding the impact of religious involvement on ratings of social competence. Another possible limitation in our study was that participants' preexisting biases toward church and community activities were not determined. Though duration, frequency and characteristics of the activities were matched in both vignette conditions, it is possible that some participants considered
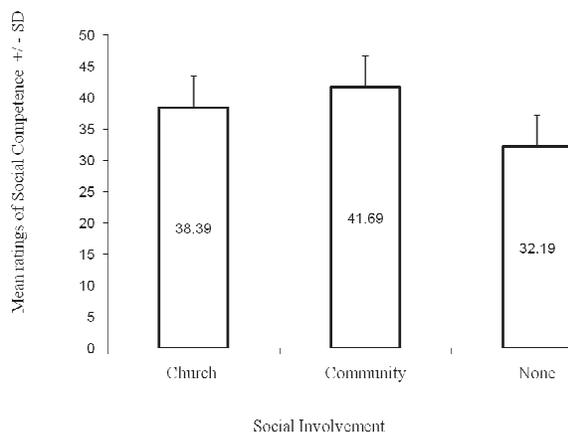
activities held in churches to be formal and ceremonial with little social interaction with people. This could have produced perceptions in line with Yossifova and Lewenthal's findings (1999) that religion is considered to foster poorer mental health in terms of promoting obsession and rigidity. On the other hand, community activities might be viewed as being entertaining and relaxing with many socializing opportunities.

The Virginia Tech Study

Midway through our data collection, on April 16, 2007, the tragic Virginia Tech Massacre occurred. **When the** identity of the killer was revealed, the public was introduced to the darkest side of mental illness. In addition to sympathy and lamenting, the stigma of mental illness might also have been activated and reinforced in society. While most acts of violence are not committed by individuals with mental illness, the stigma of mental illness can be fed by a belief in that relationship. Therefore, it is possible that this event could have served as a historical confound in our study. If that was the case, subjects who participated in the experiment after April 16 might have responded differently than those who participated prior to the Virginia Tech event. Since exactly half of our subjects participated before the event and half afterwards, we were able to run a statistical analysis to see if that event had a significant effect on perceptions of social competence of the character portrayed in our vignette.

First of all, we considered the Virginia Tech Massacre as a separate independent variable and examined the overall means of perceived social competence before and after the event. An independent samples t test was conducted but revealed no significant effect, $t(49) = 0.959$, $p = 0.342$. This finding suggested that the Virginia Tech event did not produce a historical confound in this study. In order to further explore the effect of this event, we added the Virginia Tech Massacre as a third independent variable with two levels, pre-shootings and post-shootings. A three-way ANOVA was conducted on this 2 x 3 x 2 (mental illness X social involvement X Virginia Tech) design. We hypothesized that the highly stigmatized characters in the vignettes would be judged more harshly on perceived social competence after the shootings than before the shootings. However, the addition of Virginia Tech as a third variable did not produce any significant main effect, $F(1, 48) = 1.021$, $p = .319$, and no significant interactions were found between this new variable and the two original variables, $F(2, 47) = 0.462$, $p = .633$. Additionally, we were curious about whether this shooting event would affect participants' opinions about mental illness sufferers in some specific areas, especially in areas of social interaction and perceived dangerousness. We purposely

chose four relevant questions to conduct this analysis. Two of the questions were from the demographic survey, which asked participants "How likely is it that you would be a friend of a person with a mental illness?" and "How likely is it that you would feel comfortable living near a person with a mental illness?" The other two questions came from the Judgment of Social Competence Questionnaire. These questions were "How likely is it that the character would pose a danger or threat to others?" and "How likely is it that the character would be avoided by others in the society?" Independent samples t tests were conducted to compare the mean ratings of these individual questions before and after the event. However, no significant effects were found on any of these opinion measures: willingness to be a friend ($t(48) = .321$, $p = .749$), willingness to live near ($t(48) = .928$, $p = .358$), danger ($t(48) = -.842$, $p = .404$), or avoidance ($t(48) = .289$, $p = .774$).

There are several possible explanations for a lack of effect relative to the Virginia Tech Massacre as either a separate variable or a third independent variable. First, there was only a short time gap between the event's occurrence on April 16 and our third and fourth experimental trials, which were conducted on April 17 and April 20. At that time, participants might not have had enough time and information to fully process the event. Another possible factor might be that at the time of those two trials, the killer has not been identified in the media with any specific mental disorder. Participants might not have been able to associate the killer's condition with schizophrenia when they participated. Moreover, making judgments about the social competence of the mentally ill only is an *indirect* way to assess mental stigma. Thus, even though the Judgment of Social Competence Questionnaire might be a strong test to measure the effect of perceived religiosity, it might not be sensitive enough to capture the effect of the Virginia Tech Massacre on people's stigmatizing attitudes towards the mentally ill.

Though it is possible that failure to support certain hypotheses was the consequence of a relatively small sample (only 8-9 subjects for each vignette), the content of vignettes and the strength of the religiosity variable might be improved by describing the character's religious beliefs rather than the church activities they attend. This will allow a more sensitive measure of the direct relationship between religion and mental illness stigma. Moreover, our results suggest that it is not the particular type of social involvement that matters, but perhaps the engagement in social activity itself that impacts people's perceptions of the mentally ill. Corrigan and his colleagues (2001) found that contact with someone who shows symptoms of mental illness does more to reduce stigma than other anti-stigma strategies,

such as education or protest. It is possible that simply knowing that someone with mental illness is engaging in social activities offers a kind of vicarious contact. This would underscore a need for more positive portrayals of people with mental illness in the media, a need that has been addressed by United States Substance Abuse and Mental Health Services Administration (SAMSHA) with Voice Awards to recognize entertainment programming that writes "dignified, respectful, and accurate portrayals. . .into their scripts, programs, and productions." (Department of Health and Human Services, n.d.) The outcome and success of such an approach to the reduction of stigma is an area worth exploring as a way to encourage effective social acceptance to those who suffer from mental disorders.

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APPENDIX

Judgment of Social Competence Questionnaire

(These are the questions subjects will be asked to complete after reading the scenario and definition of the disorder. The character's name will be changed according to the disorder given.)

NOW ANSWER EACH OF THE FOLLOWING QUESTIONS ABOUT C.R. BY CIRCLING THE NUMBER THAT BEST DESCRIBES YOUR PERCEPTION OF C.R.

	1	2	3	4	5
	Not at all likely				Definitely

1. How likely is it that C.R. will approach others positively?

	1	2	3	4	5
	Not at all likely				Definitely

2. How likely is it that C.R. would be able to engage in an appropriate and intelligent conversation with others?

	1	2	3	4	5
	Not at all likely				Definitely

3. Is it likely that involvement in the church is beneficial for C.R.?

	1	2	3	4	5
	Not at all likely				Definitely

4. How likely is it that C.R. would interact nonverbally with others with smiles, waves, nods, and other positive gestures?

	1	2	3	4	5
	Not at all likely				Definitely

5. How likely is it that C.R. will pose a danger or threat to others?

	1	2	3	4	5
	Not at all likely				Definitely

6. Should other people who have this mental illness be encouraged to become active in a local church?

	1	2	3	4	5
	Definitely Not				Definitely

7. How likely is it that C.R. would be willing to help other people who are in crisis?

	1	2	3	4	5
	Not at all likely				Definitely

8. How likely is it that C.R. would be described by others as being a good listener?

	1	2	3	4	5
	Not at all likely				Definitely

9. How likely is it that C.R. would be able to respect and comply with authority figures in society?

	1	2	3	4	5
	Not at all likely				Definitely

10. How likely is it that C.R. would be considered an understanding and supportive friend?

	1	2	3	4	5
	Not at all likely				Definitely

11. How likely is it that C.R. would be able to share and discuss ideas comfortably in front of other people?

	1	2	3	4	5
	Not at all likely				Definitely

12. How likely it is that C.R. would be avoided by other people in the society?

	1	2	3	4	5
	Not at all likely				Definitely

13. How likely is it that C.R. displays the capacity for humor?

	1	2	3	4	5
	Not at all likely				Definitely

14. How effective is C.R.'s religious involvement in helping him cope with mental illness?

	1	2	3	4	5
	Bad				Excellent