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Original article

General population attitudes in mental disorders: an investigatory study on psychiatric disorders and religion beliefs

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SUMMARY

Background

The literature recognizes the importance of the relationship between religion and mental health. The aim of this study is to assess whether there is a greater tolerance towards other people with psychiatric disorders or not, according to the religious beliefs of the respondent. The knowledge and attitudes of the population of the provinces of Lecce and Matera in relation to their religious beliefs were assessed through a cross sectional, multicentric study.

Methods

The study is observational, cross-sectional, multicenter and covered the population of the provinces of Lecce and Matera from May 2019 to April 2021. The validated questionnaire "Stigma study 2.0: Analysis of the stigmatization process towards those suffering from mental disorders"was administered.

Results

A total of 642 subjects voluntarily agreed to the study. Of these, 132(20.56%) declared to be atheists and 510(79.44%) declared to be believers. Statistical significance is evident between the two groups in the sphere of "Authoritarianism": believers show higher levels of authoritarian beliefs than atheists (item no.2: p = .027; item no. 3: p = .021; item no. 4: p = .003; item no. 5: p < .001). In the sub dimension of "Benevolence" only in item no. 2 "More tax money should be spent on the care and treatment of the mentally ill" the religious group is more convinced than the atheist group (p = .021). In the sub-dimension "Social restrictiveness", all the items are significantly different between the two groups: the group of believers is more convinced that psychiatric patients should be more responsible and should be more involved in the social context. Finally, also in the fourth and last sub-dimension, the religious group registers a higherlevel of conviction on the possibility that the psychiatric patients should live integrated in the social fabric, in the common territory and that they do not represent any threat to anyone in their neighbourhood.

Conclusions

In light of the results obtained in the present study and the data available in the literature, it seems that the concept of religiosity/spirituality of the participants is of fundamental importance in the global conception of well-being in a holistic vision of the patient with full respect for the beliefs and spiritual/religious practices of their patients and their families and caregivers.

Key words: attitude, mental disorders, psychiatry, religion

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Background

Over the centuries, the concept of mental illness has undergone an important evolution, taking on different meanings and nuances with the passing of the ages. The history of mental illness is marked by a series of laws which, over time, have enhanced the dignity and protection of the subject with mental disorders. The organization and management of health care for mentally ill offenders who have been subjected to a restraining order (precautionary measure, detention and non-custodial security measure) have deeply changed [1]. According to the World Health Organization (WHO), the global burden of mental disorders continues to grow with a consequent impact on health and major social, human and economic aspects in all countries of the world. In 2001, the WHO estimated that the percentage of people worldwide who had been diagnosed with a psychiatric condition – at least once in their lifetime – was around 25% [2]. According to the *Global Burden of Disease Study* 2017, the most recent and comprehensive analysis on global epidemiological trends, mental disorders account for more than 14% of disability-adjusted life years (DALYs) [3]. In 2012, the most common mental disorders were depression, bipolar disorder, schizophrenia, and anxiety disorders. These disorders were the cause of 12% of all disabilities and, among them, depression causes the greatest degree of disability [4]. The COVID-19 pandemic, in addition to the casualties directly caused by the virus and its pathological sequelae and the residual disability from many "cured" conditions, has had and will have an extraordinary impact on the mental health of the entire population. Because of the pandemic, data in the literature concur that most individuals have an increased risk of developing mild to moderate psychopathological symptoms and that some have an increased risk of developing more severe and disabling symptoms [5,6]. The history of health emergencies – especially epidemic ones – teaches that issues related to fear, uncertainty, and stigma recur with high frequency, representing important obstacles to the implementation of timely and effective preventive and curative interventions for both the general population [6,7] and particular categories of professionals [8-10]. Stigma is a complex term that includes issues of knowledge (ignorance or misinformation), attitude (prejudice) and behavior (discrimination). In the case of mental illness, stigma has peculiar characteristics, analyzed in a research published in *Lancet* [11]. Mental illness stigma is an indelible social mark that personalizes the mentally ill person and is also projected onto the socio-family group to which they belong. It is still present today and is one of the main obstacles to therapy and care programs for psychiatric patients [12]. It is important to distinguish two forms of stigma: "public stigma" and "self-stigma"; they represent a true "second disease" because of their significant impact [13]. The person affected by mental disorders loses his or her identity and identifies with the illness. The triggering of the mechanisms that characterize and constantly feed the process of stigmatization often has as its most severe effect the failure of the person with mental disorders to seek counseling. Empirical studies have shown that perceived stigma is correlated with a more negative attitude towards seeking help and it is evident how discrimination increases the risk of poor mental wellbeing outcomes [14,15].

Perceived "public stigma" can lead individuals to avoid seeking help because they expect others to discriminate against and devalue psychiatric service users [16]. "Self-stigma" can also lead individuals to avoid seeking help because self-stigma affects feelings of self-worth and self- efficacy. In addition, the relationship between stigma and help-seeking has gender differences. Studies consistently show that women are more likely to seek help for emotional issues [17] and possess more positive attitudes toward counseling than men [18]. One of the most widespread prejudices about mental illness is that of social dangerousness, understood as the likelihood that a mentally ill individual will engage in self- and hetero-aggressive behaviour, a prejudice that was, however, taken as a fundamental criterion for internment in asylums, according to the 1904 Act [19]. The person suffering from mental illness, being perceived by the community as a potentially violent subject, because of his disorder, is therefore a person to be avoided, thus fortifying the process of exclusion. Another widespread prejudice is that the mentally ill are in some way responsible for their disorder: they could control it but instead they give in to it because they are too weak to resist it. Another common prejudice is that of incurability: instead, there are many effective tools, both pharmacological and psychotherapeutic, which allow one to recover part or all of one's social and intellectual abilities, without forgetting that treatments are more successful the earlier the diagnosis is made [20]. Research has shown that, among the general population, the implementation of a social distance towards people with mental illness is widespread. This distances the individual with psychological suffering even further from the start of the treatment most appropriate to his clinical condition, causing a worsening of negative emotions and a reduction in positive ones with unfavorable results, such as depression, anxiety and low self-esteem [21,22].

According to the National Comorbidity Survey, nearly a quarter of people who seek help for a mental health problem in a given year seek it from a member of the clergy [23]. The literature also shows that many psychiatric illnesses have inverse correlations with religiosity. With regard to physical health, religiosity correlates with

decreased smoking and alcohol consumption, as well as positively influencing heart disease and blood pressure. In addition, the psychological resources provided by religious involvement could prevent the adverse effects of stress on one's sense of self [24]. Religious commitment and participation also appear to affect longevity, especially in men [25], and faith may enable members of religious groups to develop and maintain meaning in their lives and thus improve their well-being [26].
Suicide rates were found to have a negative correlation with religiosity. Suicide ideology was also reduced, as were more disapproving attitudes toward suicidal behavior [27] and attending religious places, such as churches, was an important predictor in suicide prevention. A study published in 2012 in the American Journal of Psychiatry highlighted the important association between religiosity and depression: the study through a 10-year follow-up found a long-term protective effect of high personal importance of religion/spirituality against major depression, whose participants with high personal importance of religion/spirituality had about a quarter of the risk, compared to other study participants, of having an episode of depression in a 10-year prospective period, as well as follow-up examinations of the children of depressed patients whose parents' depression status determined the high-risk status of their offspring, in which those who reported a high importance of religion or spirituality had about one-tenth the risk of experiencing major depression between the ages of 10 and 20 than those who did not [28]. A negative correlation between drug use and religiosity has also been reported. Church attendance was found to be more of an indicator of drug and alcohol abstinence [29]. Thus, it has been seen that religiosity can be associated with better mental health, in particular it can reinforce self-concept in a positive way and create a personal respite that can allow negative emotions to subside [30]. A study conducted among a population of university students in Jordan showed a significant correlation between religiosity and stigma towards mental disorders [31]. This study indicated the need to disseminate some religious principles to reduce stigma, such as to assume a non-stigmatizing positive attitude towards mental disorders, thus recognizing the importance of the relationship between religion and mental health. In this regard, starting from this assumption, we want to investigate whether religiosity can positively influence social stigma towards psychiatric pathology. Therefore, the aim of this study is to assess whether the religious beliefs of the respondent can have a greater tolerance towards other people with psychiatric disorders or not, evaluating through a cross sectional, multicenter study, the knowledge and attitudes of the population of the provinces of Lecce and Matera in relation to their religious beliefs.

Materials and methods

The is an observational, cross-sectional, multicentric study and involved the population of the provinces of Lecce and Matera, Italy.

Recruitment criteria

It was included all the population who agreed to participate in the study, signing the informed consent and having the following requirements: Age between 18 and 80 years old, who lived in the Southern of Italy, especially in Lecce and Matera provinces. The questionnaire was developed through the Google Moduli function and disseminated through some Facebook and Instagram local pages in order to publicize the study and to invite general population to answer the questionnaire. Subjects who were under and over age and those who did not agree to participate in the study or did not complete questionnaires were excluded. Each participant could join the survey by connecting to the local social pages.

Operating timing

From May 2019 to April 2021.

Sampling and instruments

The questionnaire was administered to the general population in the Southern of Italy, especially in the provinces of Lecce and Matera. The first part f the questionnaire collected socio-demographic and professional information, such as: sex, marital status, educational qualification, profession, age, religious beliefs. The second part of the questionnaire contained the Community Attitudes Toward The Mentally Ill questionnaire (CAMI), which consisted in 40 statements concerning the degree of information and sharing of mental health treatments and services and the degree of acceptance and tolerance towards the individual with mental disorders in the community. Responses to each item were based on a 5-point Likert scale ranging from 1 (Fully agree) to 5 (Totally disagree) [32,33].

Data analysis

The data were collected in an Excel spreadsheet and processed with the SPSS program version 20. All sampling characteristics were considered as categorical variables and presented as frequencies and percentages. All the values of each CAMI item were evaluated according to the variable of religious belief through the MANOVA test.

Results

A total of 642 subjects voluntarily joined the study. Of these, 132(20.56%) declared themselves to be atheists and 510(79.44%) declared themselves to be believers. For the purpose of the present study, the type of belief is not of interest, but it was only necessary to know

whether the participants had a religious belief or not, regardless of the type of belief. All socio-demographic characteristics of participants were collected in the Table I.
In the Table II stigma perceived by general population on mental disorders were collected.
The data reported in Table III showed how statistical significance was highlighted between the two groups in the sphere of "Authoritarianism": believers showed higher levels of authoritarian beliefs than atheists (item no. 2: p = .027; item no. 3: p = .021; item no. 4: p = .003; item no. 5: p < .001). While in the sub dimension of "Benevolence" only in item no. 2 "More tax money should be spent on the care and treatment of the mentally ill" the religious group was more convinced than the atheist group (p = .021). In the sub-dimension "Social restrictiveness" all the items were significantly different between the two groups: the group of believers was more convinced that psychiatric patients should be more responsible and should be more involved in the social context. Finally, also in the fourth and last sub-dimension the religious group registered a higher level of conviction on the possibility that the psychiatric patient should live integrated in the social fabric, in the common territory and that he did not represent any threat to anyone in his neighborhood (Tab. III).

Discussion

The present study aimed to investigate how religious belief could influence the acceptability of psychiatric patients in the social network. The data recorded showed a high level of significance on the subject, that is: those who had a religious belief have a greater tolerance towards psychiatric patients, imagining them more integrated in their territory and in the social network.
In the literature as early as 1969, after reviewing research in this area, Victor Sanua stated, "The thesis that religion as an institution has been instrumental in promoting general welfare, creativity, honesty, liberalism, and other qualities are not supported by empirical data. […] there were no scientific studies showing that religion was capable of serving mental health" [34]. In this regard, therefore, the importance of religious belief in psychiatric pathology and perceptions of it was perceived, but no hard data was evinced to prove its actual effectiveness. Later, Larson et al. [35] also challenged this view by conducting systematic reviews of quantitative research on religion in psychiatry. In 1986, only 2.5% of articles delving into aspects of mental health included a religious variable. Six years later, they evaluated all measures of religious commitment reported in research studies published in two leading psychiatry research journals from 1978 to 1989, recording 139 religious measures, examined in 35 studies. In contrast to Sanua's conclusion, they found that 72% of the studies reported a positive relationship between religious involvement and better mental health, 16% worse mental health, and 12% no correlation [36]. For many years, the work of Larson and colleagues served as a state-of-the-art review of associations between religion and mental health. It is therefore evident the need to give voice, through the dialogue between patient and physician, to the experience of the individual, that dimension which may not be immediately observable, or decipherable, but which represented for each individual the connective tissue on which his or her existence developed, and to give voice to the network of cultural and religious factors which determined the existential framework [37].
However, there were no studies in the literature that could be overlapped on ours in terms of purpose and conclusions, since the literature highlights the importance of religious beliefs for psychiatric pathology and not for the behavioral intentions of society towards mental pathology and how these could be mitigated or not by a religious belief, whatever it may be. "*The sore point of human relationality is always that which arises from the endless search for our identity through the confrontation with the other from us, identity seems to be the issue on the agenda, the myth that unites and divides at the same time. Hence the drama of the inclusion of the other from oneself, in its different conjugations, whether it is a subject with a different religious faith or who has behaviors considered not normal*" [37]. Therefore, our study turned out to be a pilot in this: religiosity could have positive effects on both the psychiatric patient and society in the anti- stigma struggle against psychiatric pathology. From the present results, a significant association emerged between religious belief and the item no. 2, as a prejudice against those suffering from a mental disorder clearly was highlighted. In support of our study, religiosity has been shown to have a significant positive effect for prevalence, especially depressive and substance use disorders. In fact, from diagnosis and differentiation between spiritual experiences and mental disorders; and also treatment in help in behavioral research, compliance, mindfulness, and treatment adjuncts and finally outcomes, as: in recovery, suicide, and moreover prevention; as well as for quality of life and well-being of the psychiatric patient [38,39]. Despite this, in 2014, participants with Major Depressive Disorder reported more discrimination against certain areas of life including religious than participants with schizophrenia [40]. Another aspect concerns prejudices and discrimination based on religious reasons which continued to be widespread; although freedom of belief and religious expression are today fundamental rights integrated into the European Convention on Human Rights. In this regard, the World Health Organization (WHO) has also included religiosity

as a dimension of quality of life [41]. However, the literature is debated in considering religion as a beneficial factor on mental health outcomes or as an obstacle to it, as in the case of treatment refusal, intolerance, negativity religious coping, since several surveys have shown that religious values, beliefs and practices are important concerns in addressing health care for most of the world population [42-44]. Understanding mental illness as a treatable medical condition might influence stigmatizing beliefs, but evidence available to inform this hypothesis was derived exclusively from high-income countries as emerging from the item no. 9 of the Social Restrictiveness sub dimension. From a randomized study conducted among the South-Western Uganda population it emerged that portrayals of effectively treated mental illness did not appear to reduce endorsement of stigmatizing beliefs about mental illness or about persons with mental illness [45]. In a collection of 2,800 studies [46], it was found a positive correlation between religion and spirituality and mental and physical health. From this point of view, therefore, it is important to consider the patient as a whole and take into account all the factors that affect mental health, including religion in the "Core Training Curriculum for Psychiatry" [47].

Limitations of the study

The results of the study might be considered taking into account some limits that mainly concern the choice of electronic disclosure of the questionnaire which might partially have
excluding people with a limited computer background. Furthermore, it was not always possible to compare the results of ours study with those already present in the literature, as scarce for how much it concerns the correlation between religious belief and the stigma towards whom suffered from mental disorders.

Conclusions

In light of the results obtained in this study and the data available in the literature, it seems that the concept of religiosity/spirituality of the patient is of fundamental importance in the global conception of well-being in a holistic view of the patient with full respect for the beliefs and spiritual/religious practices of their patients and their families and caregivers. Therefore, the hope for future studies is to further cultivate these theoretical assumptions in the light of the World Psychiatric Association, which in its proposals on religion/spirituality in mental health proposes a careful consideration of patients' religious beliefs and practices, as well as their spirituality, which should be regularly considered in the psychiatric history; an understanding of religion and spirituality and their relationship with the patient's psychiatric diagnosis. These assumptions should also be the subject of continuing education in psychiatry in order to better understand the patient as a whole, demonstrating a broader awareness of, respect for, and sensitivity to spirituality and religiosity in support of the promotion of health and well-being [48].

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Conflict of interest statement

The Authors declare no conflict of interest.

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Authors' contributions

All Authors equally contribuited to the work.

Ethical considerations

Ethical concerns of the study were stated within the presentation of the questionnaire. Participation in the study, being free and voluntary, was considered an expression of consent. It was emphasized that participation was voluntary and that the participant could refuse participation in the protocol whenever he/she wished. Those interested in participating were presented with the opportunity to express informed consent and the confidentiality and anonymous nature of the information was guaranteed according to the Declaration of Helsinki principles.

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TABLE I. *Sampling characteristics (n = 642).*

Sampling characteristics	n(%)
Sex	
Female	390(60.70%)
Male	252(39.30%)
Age	
31-40 years	443(69.00%)
41-50 years	54(8.40%)
51-60 years	55(8.60%)
61-70 years	69(10.70%)
> 71 years	16(2.50%)
	5(0.80%)
Religion	
Believer	510(79.40%)
Atheist	132(20.60%)
Marital status	
Single	443(69.00%)
Married	151(23.50%)
Cohabitant	29(4.50%)
Divorced	16(2.50%)
Widower	3(0.50%)
Educational level	
Elementary	4(0.60%)
Lower average	47(7.30%)
Diploma	439(68.40%)
Degree	152(23.70%)
Job role	
Student/trainee	352(50.60%)
Worker	265(41.30%)
Not employed/retired/housewife	52(8.10%)

TABLE II. *Perception of psychiatric disease.*

Questions/answers	N (%)
Item no. 1: In the province where you live, are there facilities to welcome people with mental disorders?	
Yes	509(79.30%)
No	133(20.70%)
Item no. 2: Do you know the name of any Mental Disorder?	
Yes	546(85.00%)
No	96(15.00%)
Item no. 3: Do you think there is a difference between Mental Retardation and Mental Disorder?	
Yes	557(86.80%)
No	28(4.40%)
I don't know	57(8.90%)
Item no. 4: Can you recognize someone with a mental disorder?	
Yes	539(84.00%)
No	103(16.00%)
Item no. 5: I am afraid of people with mental illness	
Very unlikely	106(16.50%)
Unlikely	205(31.90%)
Uncertain	194(30.20%)
Likely	118(18.40%)
Very likely	19(3.00%)
Item no. 6: Would you have any objections to having people with mental illness in the neighborhood?	
Very unlikely	225(35.00%)
Unlikely	220(34.30%)
Uncertain	127(19.80%)
Likely	51(7.90%)
Very likely	19(3.00%)
Item no. 7: Would you avoid a conversation with neighbors who have suffered from a mental illness?	
Very unlikely	300(46.70%)
Unlikely	224(34.90%)
Uncertain	62(9.70%)
Likely	37(5.80%)
Very likely	19(3.00%)
Item no. 8: Would you work with someone who has a mental illness?	
Very unlikely	32(5.00%)
Unlikely	83(12.90%)
Uncertain	169(26.30%)
Likely	230(35.80%)
Very likely	128(19.90%)
Item no. 9: Would you invite someone home if you know they have suffered from a mental illness?	
Very unlikely	35(5.50%)
Unlikely	47(7.30%)
Uncertain	111(17.30%)
Likely	279(43.50%)
Very likely	170(26.50%)
Item no. 10: Would you be worried about visiting someone with a mental illness?	
Very unlikely	187(29.10%)
Unlikely	230(35.80%)
Uncertain	125(19.50%)
Likely	77(12.00%)
Very likely	23(3.60%)

TABLE II. *continue.*

Questions/answers	N (%)
Item no. 11: Would you accept as a friend a person who was a psychiatric patient in the past?	
Very unlikely	22(3.40%)
Unlikely	31(4.80%)
Uncertain	94(14.60%)
Likely	262(40.80%)
Very likely	233(36.30%)
Item no. 12: If someone who was a psychiatric patient in the past came to live in the apartment next to yours, would you greet them if you happen to meet them?	
Very unlikely	15(2.30%)
Unlikely	7(1.10%)
Uncertain	12(1.90%)
Likely	145(22.60%)
Very likely	463(72.10%)
Item no. 13: If this happens to you, would you have a conversation with a neighbor who has suffered from a mental illness?	
Very unlikely	9(1.40%)
Unlikely	9(1.40%)
Uncertain	32(5.00%)
Likely	226(35.20%)
Very likely	366(57.00%)
Item no. 14: If someone who was a psychiatric patient in the past came to live in the apartment next to yours, would you go and visit him?	
Very unlikely	27(4.20%)
Unlikely	49(7.60%)
Uncertain	145(22.60%)
Likely	295(46.00%)
Very likely	126(19.60%)

TABLE III. *Community attitudes toward the mentally ill according to religious belief in the Southern Italian population (n = 642).*

Scale/sub-dimensions according to religious belief	Atheist (n = 132; 20.56%) μ ± s.d.	Believer (n = 510; 79.44%) μ ± s.d.	F	p
Authoritarianism:				
One of the main causes of mental illness is a lack of self-discipline and will power	2.63 ± 0.98	2.82 ± 1.02	3.804	.052
The best way to handle the mentally ill is to keep them behind locked doors	1.42 ± .73	1.60 ± .81	4.941	.027*
There is something about the mentally ill that makes it easy to tell them from normal people	2.90 ± .85	3.12 ± .89	6.341	.012*
As soon as a person shows signs of mental disturbance, he should be hospitalized	2.13 ± .91	2.41 ± .98	9.011	.003*
Mental patients need the same kind of control and discipline as a young child	2.30 ± .93	2.70 ± 1.03	16.217	< .001*
Mental illness is an illness like any other	3.06 ± 1.09	3.16 ± 1.20	.762	.383
The mentally ill should not be treated as outcasts of society	4.29 ± 1.06	4.27 ± 1.03	.060	.806
Less emphasis should be placed on protecting the public from the mentally ill	2.74 ± 1.18	2.90 ± 1.16	1.864	.173
Mental hospitals are an outdated means of treating the mentally ill	3.79 ± 1.15	3.59 ± 1.22	2.980	.085
Virtually anyone can become mentally ill	4.04 ± .88	4.11 ± .83	.679	.410
Benevolence:				
The mentally ill have for too long been the subject of ridicule	3.92 ± 1.02	3.91 ± 1.02	.000	.992
More tax money should be spent on the care and treatment of the mentally ill	4.06 ± .87	4.24 ± .77	5.321	.021*
We need to adopt a far more tolerant attitude toward the mentally ill in our society	4.17 ± .82	4.26 ± .72	1.561	.212
Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for	3.36 ± .98	3.43 ± .96	.580	.447
We have a responsibility to provide the best possible care for the mentally ill	4.38 ± .85	4.34 ± .73	.208	.649
The mentally ill don't deserve our sympathy	1.32 ± .66	1.43 ± .68	2.563	.110
The mentally ill are a burden on society	1.57 ± .82	1.56 ± .73	.066	.797
Increased spending on mental health services is a waste of tax dollars	1.50 ± .65	1.53 ± .68	.226	.635
There are sufficient existing services for the mentally ill	2.43 ± .80	2.42 ± .80	.017*	.896
It is best to avoid anyone who has mental problems	1.72 ± .77	1.76 ± .81	.277	.599

TABLE III. *continue*

Scale/sub-dimensions according to religious belief	Atheist (n = 132; 20.56%) μ ± s.d.	Believer (n = 510; 79.44%) μ ± s.d.	F	p
Social restrictiveness:				
The mentally ill should not be given any responsibility	2.31 ± .94	2.51 ± .94	4.621	.007*
The mentally ill should be isolated from the rest of the community	1.48 ± .70	1.47 ± .68	.002	< .001*
A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered	1.76 ± .86	1.90 ± .87	2.812	.004*
I would not want to live next door to someone who has been mentally ill	1.86 ± .93	1.99 ± .94	2.255	.004*
Anyone with a history of mental problems should be excluded from taking public office	2.08 ± .87	2.30 ± .94	5.559	.009
The mentally ill should not be denied their individual rights	3.97 ± 1.23	4.02 ± 1.13	.212	< .001*
Mental patients should be encouraged to assume the responsibilities of normal life	3.97 ± .89	4.04 ± .77	.845	.001*
No one has the right to exclude the mentally ill from their neighborhood	4.45 ± .79	4.38 ± .80	.805	.001*
The mentally ill are far less of a danger than most people suppose	3.79 ± .93	3.72 ± .89	.637	.001*
Most women who were once patients in a mental hospital can be trusted as babysitters	3.03 ± .82	2.90 ± .82	2.615	.004*
Community mental health ideology:				
Residents should accept the location of mental health facilities in their neighborhood to serve the needs of the local community	3.99 ± .89	4.01 ± .80	.059	<.001*
The best therapy for many mental patients is to be part of a normal community	4.03 ± .88	4.12 ± .75	1.432	.002*
As far as possible, mental health services should be provided through community based facilities	4.17 ± .88	4.17 ± .73	.006	< .001*
Locating mental health services in residential neighborhoods does not endanger local residents	3.90 ± .99	3.82 ± .95	.761	.001*
Residents have nothing to fear from people coming into their neighborhood to obtain mental health services	4.08 ± .89	3.95 ± .82	2.637	.004*
Mental health facilities should be kept out of residential neighborhoods	2.13 ± .95	2.17 ± .89	.185	< .001*
Local residents have good reason to resist the location of mental health services in their neighborhood	2.01 ± .96	2.18 ± .92	3.486	.005*
Having mental patients living within residential neighborhoods might be good therapy but the risks to residents are too great	2.30 ± .95	2.38 ± .86	.736	.001*
It is frightening to think of people with mental problems living in residential neighborhoods	1.84 ± .80	1.93 ± .82	1.231	.002*
Locating mental health facilities in a residential area downgrades the neighborhood	1.73 ± .84	1.76 ± .77	.131	< .001*

**p < .05 is statistically significant.*