ORIGINAL ARTICLE

Stigma in Mental Illness: Attitudes of Medical Students Towards Mental Illness

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Summary

Background: Negative attitudes towards people with mental illness can be attributed to stigma. The objective of this study was to determine the attitudes of medical students towards mental illness by comparing those who have had contact with mental patients and those who have not. This study also assesses to what extent knowledge about mental illness can affect the students' attitude.

Methods: A vignette and two dependent measures (social distance scale and dangerousness scale) were used to assess the attitudes of medical students towards mental illness. They comprised of 108 first year and 85 final year medical students in University of Malaya, Kuala Lumpur. The first year students didn't have any prior psychiatric training.

Results: The final year students who had knowledge and contact (undergone 8 weeks of clinical psychiatric training) were less stigmatizing toward mentally ill patients. There were no significant differences in the attitudes towards mentally ill patient among the first year students (no knowledge) regardless they had previous contact or not.

Conclusion: Knowledge seems to have the effect in inculcating greater tolerance of mental illness. Contact by itself is not sufficient for attitude changes.

Key Words: Stigma, Attitude, Mental illness

Introduction

Stigma is a mark of infamy or disgrace. People who have been stigmatized are subject to abuse and social exclusion. Negative attitudes towards people with mental illness are attributed to stigma. Social attitudes towards people with mental disorders dates back to the prehistoric era, they were believed to be 'possessed by unclean spirits' or a devil. In American Colonial days they might be burned as witches[1]. People diagnosed with mental illnesses inhabit a different space in

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public perception from those hospitalized for 'physical' conditions such as cancer or heart disease [2]. It was perceived that mentally ill people not only acted differently but also looked different [3]. The main difference was that the cause of the mental illness was attributed to emotional difficulties rather than to specific physiological pathology[4]. A person hospitalized for mental illness was assumed to be dangerous, incompetent, and untrustworthy[5].

Stigma affects the patient's interactions, social network, employment opportunities and quality of life in general. It also lowers the identified patient's self-esteem and contributes to a disrupted family relationship[4]. Stigmatization can still happen for individuals whose mental illness is in remission, even if their behavior is 'normal' just because they have been admitted to a psychiatric hospital[6]. Surprisingly stigma continues to complicate the lives of the stigmatized even as treatment improved their illness[5]. Therefore, mental illness was still perceived as an indulgence and as a sign of weakness[7].

Various studies have quoted that negative opinions about mental disorders were prevalent[5,8,9]. The most negative opinion is that people with mental disorders especially schizophrenia are dangerous [8].

With the advent of community psychiatry, the pressure of care of the mentally ill will increasingly fall on the family and the community. In order for the transition to succeed, it is important to bear in mind the attitudes of the community and the caregiver [10]. Knowledge of such attitudes is also critically important to workers involved in primary prevention programme and early intervention. Both administrators and clinicians benefit from acquaintance with public attitudes toward the presence of psychiatric facilities and patients in their neighbourhood [6].

Several studies have investigated the attitudes of medical students toward mental patients. Being a medical student does not in itself mean that they would have more positive attitudes towards the mentally ill. In fact, in certain areas, they may have even more prejudicial attitude towards the mentally ill than the general population. A study done by Huchinson et al [11] among 108 pre-clinical medical students, 89% opposed mental patients marrying into their families, and 85% opposed mental patients teaching their children.

However, Roth [12] found that the medical students' experience with mental illness in general, either through personal or professional activities, was associated with more positive attitudes towards the mentally ill. Finally, Hill [13] concluded that medical students attitudes to psychiatric patients were based upon opinions they formed in childhood, at school and university, and upon influences they encountered during pre-clinical and clinical professional training.

In Malaysia, there is limited local data available regarding the attitudes of medical students, doctors and the community towards mental illness. The aim of this study is to determine the attitudes of medical students towards mental illness by comparing those who have had contact with mental illness and those who have not. This study also assesses to what extent these attitudes had been modified by exposure to undergraduate psychiatric training of mental illness.

Materials and Methods

Location of Study

The study was carried out in the Faculty of Medicine, University of Malaya. The faculty offers an extensive exposure in psychiatric curricula especially in the final year when students undergo eight weeks of psychiatric posting. This would include lectures, tutorials, case presentations, and seminars.

Study samples
All the first year pre-clinical and final year clinical students from Faculty of Medicine, University of Malaya were selected for this study. Knowledge of mental illness is defined as having undergone 8 weeks of lectures, seminars on psychiatric topics and interaction with psychiatric patients through 8 weeks of clinical psychiatric posting.

Study Instruments
Questionnaire (Annex A)
The students were assessed by using a self-administered questionnaire that consisted of three sections. The first section was to investigate the demographic data of the study population, i.e. year of study, age, race and sex. The second section was to assess whether the students had any contact with a mentally ill patient, by asking whether they know someone with mental illness and the duration of contact. They were asked to specify the nature of contact, whether from personal experience (having mental illness themselves), a family member, a friend, an unspecific contact, patients in the hospital and no contact at all. Students who have had contact with a mentally ill patient were asked to specify the diagnosis of the illness. In the third section, the students' knowledge of mental illness was assessed. They were questioned on some of the common diagnoses of mental illness, predisposing factors, sign and symptoms of the illness.

Vignette (Annex B)
A vignette and two dependent measures namely social distance scale and dangerousness scale, were used to assess the attitude of medical students toward mental illness. The vignette was about an individual with schizophrenia who was already in remission. The description of the individual's previous symptomatology and the conditions aftercare setting was also included. After reading the vignette, subjects were asked to answer two dependent measures, i.e. social distance scale and dangerousness scale.

Dependent measures (Annex C)
The two dependent measures used in the current study were social distance and dangerousness scales. They were used by Penn [9] and Link [14], in a study of undergraduate students and found to be valid for ascertaining attitudes toward mental illness [9]. The **social distance scale** comprises seven statements that refer to interaction with the target individual. Each statement was rated by the subjects on a 4-point Likert scale (0 = definitely willing to 3 = definitely unwilling). A composite measure of social distance is derived by totaling the sum of all statements. The higher the score, the more discrimination and stigmatization demonstrated. The internal consistency (Cronbach's alpha) of this measure was 0.75[14].

An eight-statements **dangerousness scale** with minor modification was adopted from the previous studies by Penn[9] and Link[14]. Most of the original statements were included and a few statements were amended to suit the local situation. The scale was used to gauge individual beliefs about whether a person who is, or has been, mentally ill is likely to be a danger to others. The statements pertain to the mentally ill is targeted to the individual described in the vignette. The original statement 1 which read: "If a group of former mental patients lived nearby, I would not allow my children to go to the movie theater alone" had been changed to "If a group of former mental patients lived nearby, I would not allow my children to go to the nearby shopping area alone". Statement 2 which read: "If a former mental patient applied for a teaching position at a grade school and was qualified for the job, I would recommend hiring him/her." had been changed to "If a former mental patient applied for a teaching job at a school and was qualified for the job, I would recommend hiring him/her".

Statement 6 which read: "If a former mental patient lived nearby, I would not hesitate to allow young children under my care on the sidewalk." had been changed to "If a former mental patient lived nearby, I would not hesitate to allow young children under my care to go to the playground alone". Statement 8 which read: "There should be a law forbidding a former mental patient the right to obtain a hunting license" had been changed to "There should be a law forbidding a former mental patient the right to obtain a firearm license in this country." Responses to each item were rated by the subjects on a 7-point Likert scale from "strongly disagree = 1" to "strongly agree = 7" with the midpoint being "no opinion". A high statement response indicated a more negative attitude. The original dangerousness scale had internal consistency of 0.78[14].

Data Analysis

The statistical package (Window version 9.05 SPSS) was used to analyze the data. Before analyzing the data, the data were summarized and examined using frequencies and means so as to make sure the 'outliers' data were detected and necessary steps were taken to clean the data. It should be noted that during analysis, denominators were not always equal because of the missing values.

Chi-square test were used for related samples as to assess and compare the knowledge of mental illness between first year and final year medical students. An alpha level of significance 0.05 was set for all analyses. The score of each scale was derived by totaling the sum of all statements. T-test for two independent samples (which was means of the score of each scale) was used to test the Null hypotheses.

Results

Response rate was 70.1% for first year (108 of 154) and 65.4% for the final year (106 of 162) medical students. As the study already defined what was the knowledge requirement regarding mental illness, only 85 final year medical students (52.5% - 85 of 162) had completed eight weeks of clinical psychiatric posting were selected for the analysis. Therefore, 21 final year medical students who had not yet undergone the clinical psychiatric posting were excluded from the analysis.

Interestingly 53.6% of the first year students stated that they knew someone with a mental illness. However they were unable to identify the mental disorder and one student quoted black magic as the diagnosis. The knowledge of mental illness in these two groups of students was assessed and compared in terms of the diagnoses of mental illness, the predisposing factors, signs and symptoms of the illness. The responses were shown in Table I - III. There was significant difference in the comparison of knowledge of diagnoses of mental illness between first year and final year medical students. This could be because the final year students had undergone the clinical psychiatric posting.

Table IV shows that there were significant differences of the attitudes among the medical students. Final year students who had undergone clinical psychiatric posting were less stigmatising towards mentally ill. They were more tolerant and perceived the mentally ill as less dangerous. T-tests for two independent samples in (refer Table V) showed that there were no significant differences in the attitudes towards mentally ill among the first year students regardless of whether they have contact or no contact with mental illness patients.

Table I: Knowledge of Medical Students Regarding the Common Diagnoses of Mental Illness

Diagnosis	Number Responding (N)	Response			Chi-square p
		Yes	No	Don't know	
1. Phobia					
First year	94	45 (47.9)	32 (34.0)	17 (18.1)	p<0.05
Final year	80	76 (95.0)	4 (5.0)	0 (0)	
2. Anxiety disorder					
First year	93	65 (69.9)	18 (19.3)	10 (10.8)	p<0.05
Final year	80	78 (97.5)	0 (0)	2 (2.5)	
3. Mania					
First year	95	66 (69.5)	5 (5.2)	24 (25.3)	p<0.05
Final year	80	79 (98.8)	0 (0)	1 (1.2)	
4. Depression					
First year	92	57 (62.0)	26 (28.2)	9 (9.8)	p<0.05
Final year	80	79 (98.8)	0 (0)	1 (1.2)	
5. Schizophrenia					
First year	94	66 (70.2)	0 (0)	28 (29.8)	p<0.05
Final year	79	79 (100)	0 (0)	0 (0)	
6. Mental retardation					
First year	94	48 (51.1)	32 (34.0)	14 (14.9)	p>0.52
Final year	78	37 (47.4)	37 (47.4)	4 (5.2)	
7. Epilepsy					
First year	94	29 (30.9)	35 (37.2)	30 (31.9)	p<0.05
Final year	78	8 (10.3)	69 (88.5)	1 (1.2)	

Table II: Knowledge of Medical Students Regarding the Predisposing Factors of Mental Illness

Predisposing Factors	Number Responding (N)	Response			Chi-square p
		Yes	No	Don't know	
1. Genetics					
First year	107	78 (72.9)	13 (12.1)	16(15.0)	p<0.05
Final year	85	84 (98.8)	0 (0)	1 (1.2)	
2. Life events					
First year	98	98 (91.6)	7 (6.5)	2 (1.9)	p>0.077
Final year	84	84 (98.8)	1 (1.2)	0 (0)	
3. Personality					
First year	107	61 (57.0)	28 (26.2)	18 (16.8)	p<0.05
Final year	85	83 (97.6)	2 (2.4)	0 (0)	
4. Environmental experiences					
First year	106	85 (80.2)	9 (8.5)	12 (11.8)	p<0.008
Final year	85	81 (95.3)	1 (1.2)	3 (3.5)	
5. Drugs					
First year	107	73 (68.2)	19 (17.8)	15 (14.0)	p<0.004
Final year	85	74 (87.1)	9 (10.6)	2 (2.4)	
6. Infection					
First year	107	53 (49.5)	36 (33.6)	18 (16.8)	p<0.001
Final year	84	60 (71.4)	22 (26.2)	2 (2.4)	
7. Injury					
First year	107	70 (65.4)	30 (28.0)	7 (6.5)	p>0.135
Final year	84	66 (78.6)	15 (17.9)	3 (3.6)	
8. Structural Brain Lesion					
First year	107	83 (77.6)	6 (5.6)	18 (16.8)	p<0.005
Final year	84	70 (83.3)	11 (13.1)	3 (3.6)	

Table III: Knowledge of Medical Students Regarding the Signs and Symptoms of Mental Illness

Signs and Sypmtoms	Number Responding (N)	Response			Chi-square p
		Yes	No	Don't know	
1. Unkempt Appearance					
First year	101	26 (25.7)	6 (5.9)	69 (68.3)	p<0.05
Final year	84	72 (85.7)	6 (7.1)	6 (7.1)	
2. Hallucination					
First year	104	88 (84.6)	5 (4.8)	11 (10.6)	p<0.003
Final year	84	83 (98.8)	0 (0)	1 (1.2)	
3. Delusion					
First year	104	64 (61.5)	5 (4.8)	35 (33.7)	p<0.05
Final year	84	84 (100)	0 (0)	0 (0)	
4. Sadness					
First year	105	65 (61.9)	34 (32.4)	6 (5.7)	p<0.05
Final year	83	72 (86.7)	11 (13.3)	0(0)	
5. Sleep Disturbances					
First year	104	57 (54.8)	30 (28.8)	17 (16.3)	p<0.05
Final year	84	82 (97.6)	2 (2.4)	0 (0)	
6. Guilt Feeling					
First year	104	55 (52.9)	31 (29.8)	18 (17.3)	p<0.05
Final year	84	73 (86.9)	10 (11.9)	1 (1.2)	
7. Poor Concentration					
First year	105	50 (47.6)	33 (31.4)	22 (21.0)	p<0.05
Final year	84	78 (92.9)	4 (4.8)	2 (2.4)	
8. Irrational Fear					
First year	105	87 (82.9)	4 (3.8)	14 (13.3)	p<0.004
Final year	84	82 (97.6)	1 (1.2)	1 (1.2)	

Table IV: Comparison of Means of Social Distance and Dangerousness Scale Between the First Year and Final Year Medical Students

Dependent measures	First Year (99) Mean (s.d)	Final Year (71) Mean (s.d)	Significance of independent t-test (p)
Social Distance Scale	11.75 (3.41)	10.54 (4.04)	p=0.032
Dangerousness Scale	35.38 (5.3)	31.69 (7.34)	p<0.05

Table V: Comparison of Means of Social Distance and Dangerousness Scale Between the First Year Medical Students with Contact and those without Contact with the Mentally Ill

Dependent measure	Previous contact		Significance of independent t-test (p)
	Yes(50)	No(48)	
	Means (s.d)	Means (s.d)	
Dangerousness scale	35.78 (5.42)	34.98 (5.20)	p > 0.05 (n.s.)
	Yes(49)	No(47)	
	Means (s.d)	Means (s.d)	
Social distance scale	11.90 (3.68)	11.60 (3.13)	p > 0.05 (n.s.)

Discussion

Numerous studies conducted during the past decades indicated that public attitudes towards the mentally ill were strongly negative. Since the attitudes of the general public also have an effect on community-based psychiatric care, we must ask how public opinion might be influenced. One possible approach could be through key community leaders; those who are highly respected in the society because of their competence in a particular area. Doctors belong to this group of people. This is one of the reasons why medical students, as future key community leaders, were studied here with respect to their attitudes towards the mentally ill.

Furthermore perceptions about mental illness among medical practitioners are likely to determine their capacity to recognize, appropriately treat and refer patients who have mental health problems. It is therefore important that training of medical students include psychiatry to ensure more understanding attitude towards mentally ill patients[11].

Schizophrenia elicited the most negative opinion among other mental illnesses [8]. Approximately 70% of respondents rated people with this condition as dangerous and about 80% also rated them as unpredictable.

The results of this present study suggested the presence of conditions that may reduce the stigmatization of individuals with schizophrenia. The final year students who had knowledge about mental illness were less likely to be influenced by the type of information in the vignette (Annex C). These same subjects with previous contact were also more tolerant and perceived the mentally ill as less dangerous. The first year students who had no knowledge of mental illness tended to rate the mentally ill as more dangerous and believed that more social distance should be kept from the target individual.

In a study by Byrne [15] on community knowledge of mental illness and reaction to mentally ill people had found that the negative attitudes especially among older people were fuelled by a lack of knowledge. This underscores the need to educate the public about mental illness.

In the study by Penn [9], the undergraduate students were more willing to accept the mentally ill when they had previous "contact" with those who were mentally ill. However in the current study, the first year students seem to show that they had little tolerance with the mentally ill even though they had contact previously. Therefore, knowing someone who has a mental illness is not associated with more enlightened attitudes [16]. It has been generally assumed that contact with mental patients will have a beneficial effect on the public's attitudes toward mental illness, and efforts are being made to induce the public to visit institutions, help out in volunteer programme, and otherwise associate with the patients[6].

Holmes [17] investigated changes in attitudes after the medical students and nurses have been exposed to psychiatric patients. Mental patients were brought from a hospital to participate in some of the social recreational activities. He found that there were no consistent attitude changes and the exposure to psychiatric patients had negligible effects on measures of attitudes or behavior change regarding mental illness.

It would seem that mere contact is not sufficient for attitude change, in the absence of motivation on the part of those who are exposed to mental patient. Johannsen[18] suggests tours of institutions, like tours of zoo, may arouse feelings of pity or revulsion, but never stimulate a sense of respect and empathy regarding the inmates. In short, personal contact by itself is no guarantee of attitude change.

Conclusion

From this study, it is believed that further work is required to understand attitudes towards the mentally ill by using both qualitative and quantitative methods. A longitudinal study design would be better to assess the impact of knowledge of mental illness, as the same study sample would then be followed up over a longer period. The findings of the current comparative study between the medical students may not reflect the actual attitudes of the public. It is proposed that a future study be done on a sample from the public so that the findings can be inferred to the population and the appropriate interventions can be taken from the study.

References

1. Cox C, Mead A. A sociology of medical practice. London: Collier - Macmillan, 1971; 62-245.
2. Shaw F. Mistaken Identity. Lancet 1998; 252: 1050-51.
3. Scheff T. Being Mentally ill: A sociology theory. New York: Aldine, 1966; 65-90.
4. Tuckett D. An introduction to medical sociology. Bristol: Tavistock Publication, 1976; 344-52.
5. Link BG, Struening EL, Rahav M et al. On stigma and its consequences: Evidence from a longitudinal study on men with dual diagnoses of mental illness and substance abuse. Journal of Health and Social Behaviour 1997; 38: 177-90.
6. Rabkin J. Public attitudes toward mental illness: A review of the literature. Schizophrenia Bulletin 1974; 10: 9-33.
7. Byrne P. Stigma of mental illness and ways of diminishing it. Advances In Psychiatric Treatment 2000; 6: 65-72.
8. Crisp AH, Gelder MG, Rix S et al. Stigmatization of people with mental illness. The British Journal of Psychiatry 2000; 177: 4-7.
9. Penn DL, Guynan K, Daily T et al. Dispelling the stigma of schizophrenia: what sort of information is best? Schizophrenia Bulletin 1994; 20(3): 567-78
10. Spicker P. Stigma and social welfare. New York: Croom Helm, 1984; 5-119.
11. Hutchinson G. Perceptions about mental illness among pre-clinical medical students in Trinidad & Tobago. West Indian Medical Journal 1999; 48(2): 81-84.
12. Roth D. Attitudes toward mental illness in medical students: does personal and professional experience with mental illness make a difference? Medical Education 2000; 34(3): 234-6.
13. Hill D. Acceptance of psychiatry by the medical student. British Medical Journal 1960; 1: 917-18.
14. Link BG, Cullen FT. Contact with the mentally ill and perception of how dangerous they are. Journal of Health and Social Behaviour 1986; 27: 289-303.
15. Wolff G. Community knowledge of mental illness and reaction to mentally ill people. British Journal of Psychiatry 1996; 168: 191-98.
16. Wolff G. Public education for community care: a new approach. British Journal of Psychiatry 1996; 168: 441-47.
17. Holmes D. Changes in attitudes about mental illness. New York: New York, 1968.
18. Johannsen WJ. Attitudes toward mental patient: a review of empirical research. Mental Hygiene 1969; 53: 218-28.

ANNEX A

Questionnaire

Medical student year: I / IV(S) Group:_____ Age:_____

1. Ethnic group:

1. Malay	
2. Chinese	
3. Indian	
4. Others	

2. Gender:

1. Male	
2. Female	

3. Do you know someone with mental illness?

1. Yes	
2. No	

If yes, answer No.4
If No, answer No.6

4. If you have contact with someone with mental illness, who are they?

1. Self	
2. Family member	
3. Friend	
4. Unspecified contact	
5. Patient in the hospital	

5. What do you think that person is suffering from? _____

6. Which of the following is/are mental illness?

	(1) Yes	(2) No	(3)Don't know
1. Phobia			
2. Anxiety disorder			
3. Manic			
4. Depression			
5. Schizophrenia			
6. Mental retardation			
7. Epilepsy			

7. What is the predisposing factor/factors to mental illness?

1. Genetic
2. Life events
3. Personality
4. Environmental upbringing
5. Drugs
6. Infections
7. Injury
8. Structural brain lesion

(1)Yes	(2)No	(3)Don't know

8. Which of the following is sign /symptom of mental illness?

1. Unkempt
2. Hallucination
3. Delusion
4. Sadness
5. Have trouble with sleeping and eating (Too little or too much)
6. Feeling guilty
7. Poor concentration
8. Irrational fear

(1)Yes	(2)No	(3)Don't know

ANNEX B

Read the vignette carefully and answer the following questions:

Mr. Y. S is a 32 years old man. He was diagnosed to have schizophrenia 3 years ago and hospitalised twice due to the illness. After receiving treatment, he now appears to be in remission and is doing fairly well.

Before treatment and admission to the hospital, Mr. Y.S. experiencing problems in perceiving the world around him. He would sometimes hear voices, which were hallucinations. His process of thinking was confused; he would often shift from one idea to another. At times he was difficult to understand. Mr. Y.S. demonstrated little emotional expression. He rarely smiled or got angry. He had gradually withdrawn from his family and friends so that any type of social contact was minimal. His skills in grooming and hygiene also deteriorated.

Currently, Mr. Y.S. works as a cleaner that pays RM350 per month. He gets along well with his co-workers, takes the usual coffee and lunch breaks, and tends to his job the remainder of the workday. Mr. Y.S. does his work carefully and completes each task before moving on to another. His superior never criticized him for the quality of his work.

Mr. Y.S. is clean and well groomed. He is interested to go out with his friends shopping and watching movies. He also has an ambition to get a more responsible and better paying job.

Mr. Y.S. now lives with his parents. He takes his medication regularly and goes to see psychiatrist for follow-up every 2 months.

ANNEX C

Social Distance Scale

Based on the description of Mr. Y.S, rate the following statements on the following scale:

0 = definitely willing
1 = probably willing
2 = probably unwilling
3 = definitely unwilling

1. How would you feel about renting a room in your home to someone like Mr. Y.S?	0	1	2	3
2. How about as a worker on the same job as someone like Mr. Y.S?	0	1	2	3
3. How would you feel having someone like Mr. Y.S as a neighbour?	0	1	2	3
4. How about as the caretaker of your children for a couple of hours?	0	1	2	3
5. How about having your children marry someone like Mr. Y.S?	0	1	2	3
6. How about you feel about introducing Mr. Y.S to a young woman you are friendly with?	0	1	2	3
7. How would you feel about recommencing someone like Mr. Y.S for a job working for a friend of yours?	0	1	2	3

Dangerousness Scale

Please rate the following statements on the following scale:

	Strongly Agree			No opinion	Strongly disagree		
1. If a group of former mental patients lived nearby, I would not allow my children to go to the nearby shopping area alone.	7	6	5	4	3	2	1
2. If a former mental patient applied for a teaching at a school and qualified for the job, I would recommend hiring him/her.	1	2	3	4	5	6	7
3. One important thing about mental patients is that you cannot tell what they will do from one minute to the next.	7	6	5	4	3	2	1
4. If I know a person has been a mental patient, I will be less likely to trust him.							
5. The main purpose of mental hospitals should be to protect the public from mentally ill people.	7	6	5	4	3	2	1
6. If a former mental patient lived nearby, I would not hesitate to allow young children under my care to go to the playground alone.	1	2	3	4	5	6	7
7. Although some mental patients may seem all right, it is dangerous to forget for a moment that they are mentally ill.	7	6	5	4	3	2	1
8. There should be a law forbidding a former mental patient the right to obtain a firearm license in this country.	7	6	5	4	3	2	1