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SICK AND TIRED: THE EFFECTS OF MESSAGE FRAMING AND SELF-EFFICACY ON VIEWERS OF HEALTH NEWS STORIES

A DISSERTATION

SUBMITTED TO THE GRADUATE FACULTY

in partial fulfillment of the requirements for the

degree of

Doctor of Philosophy

By

MELINDA MORRIS VILLAGRAN
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SICK AND TIRED: THE EFFECTS OF MESSAGE FRAMING AND SELF-EFFICACY ON VIEWERS OF HEALTH NEWS STORIES

A dissertation APPROVED FOR THE
DEPARTMENT OF COMMUNICATION

BY

Dan O'Hair

Sandra Ragan

Amy Johnson

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ABSTRACT

Dean, Brandes, and Dhardwadkar (1998) introduced the theoretical concept of organizational cynicism, comprised of a set of beliefs, emotions, and behavioral tendencies toward members of an organization. Capella and Jamieson (1997) discussed political cynicism, manifested as a response to the framing of mediated messages. This study combines these two approaches to the study of cynicism to explore effects of the framing of mediated health news on viewers' beliefs, emotions, and behavior toward representatives of health care organizations. In addition, viewers' self-efficacy in health care interactions is examined to explore potential response differences to health care messages. Results reveal that message frames and self-efficacy both play important roles in viewers' responses to health news content. Viewers' beliefs, emotions, and perceived behavioral tendencies were all affected by the type of organizational message viewed. While the self-efficacy of viewers did not lead to differing emotional responses after viewing the message stimulus, participants did report significantly different beliefs about health care, and perceived anticipated behavior, based on their level of self-efficacy.

CHAPTER 1

Introduction

> *Two doctors and a managed care administrator died and lined up at the pearly gates for admission to heaven. St. Peter asked them to identify themselves. One doctor stepped forward and said, "I was a pediatric spine surgeon and helped kids overcome their deformities." St. Peter said, "You can enter." The second doctor said, "I was a psychiatrist. I helped people rehabilitate themselves." St. Peter also invited him in. The third applicant stepped forward and said, "I was the director of a manager care organization. I tried to make sure people got cost-effective health care." St. Peter said, "You can come in too." But, as the managed care director walked by, St. Peter added, "You can only stay three days. After that you can go straight to hell"* (Anonymous, 2000).

Broadly defined, managed care organizations are concerned with the delivery and financing of health care (Health Care Advisory Board, 1996). During the 1980's and 1990's, the most pervasive trend in health care was an increase in the number of managed care organizations (Health Care Advisory Board, 1996). For many this trend is no laughing matter, as patients who are part of managed care organizations fear that contractual obligations, as opposed to sound medical principles, dictate the health care they receive (Morreim, 1997).

The concept of managed medical care originated in the 1920's with two organizations. In 1929, a rural farmers' cooperative health plan was established in Elk City, Oklahoma. Concurrently, a water company in Los Angeles utilized a physician-owned prepayment plan for its workers (Group Health Association News, 1988). By 1995, more than 43% of the U.S. population (approximately 112 million individuals) was enrolled in some type of managed care (HCIA Inc. and Coopers & Lybrand, 1995). It is estimated that the prevalence of managed care organizations will continue

to increase as long as increases in health care costs outpace inflation rates (McNamee, 1997).

Also in the 1920's, Winslow (1920) declared the need for "promoting health as an organized community effort for the...education of the individual for personal health, and the development of the social machinery to assure everyone a standard of living adequate for the maintenance or improvement of health" (p.23). Since that time, the public and professional health communities have sought to critically assess successful approaches to the dissemination of health promotion and disease prevention messages. Today, the media is a prominent source of information about every imaginable topic, including issues related to health.

In 1998, the Department of Health and Human Services reported that over 55% of local television stations in the United States now employ a designated health reporter. Health information is disseminated by health reporters in the "health segment" of news broadcasts. All four national networks produce regular weekly segments on issues of health. Each of these stories is framed, or presented in a particular style, by a health reporter seeking to create interesting news content. Framing of news content affects the manner in which the viewer comes to understand and interpret the issue of the story (Rhodes, 1997). As the number of news stories about health care increase, viewers' are more likely to be exposed to crucial health information from mediated sources. Therefore it is important to explore the effects of different media frames on this type of information on viewers' perceptions of their own health care.

There are several types of health information presented in news content. Innovations in preventative medicine and warnings about health concerns are increasingly common subjects of local and national news broadcasts, newspapers, and entertainment programs (Case, 1994; McGrath, 1994; Singhal & Rogers, 1999). Reporters covering health topics gather information from news releases, patients, and through relationships with local and national hospitals and pharmaceutical companies (Pfau, Mullen, & Garrow, 1995). In addition, health promotion campaigns target mediated information to specific at-risk populations (e.g., Aguirre-Molina, Ramirez, & Ramirez, 1993). Each of these sources of health information seek to educate viewers about providers, treatment options, and medical breakthroughs in health care.

As the role of the traditional family physician evolves, it is increasingly likely that Americans receive more health information from the media than from a medical professional (Buchanan, Villagran, & Ragan, 2001). For example, Okon, Lee, and Li's (1996) survey concluded that women gain more knowledge about women's health issues from mass media channels (54.5%) than from health care professionals (28%). Physicians are no longer singular sources of information about health issues. As such, no longer can managed care organizations act as gatekeepers for the dissemination of information to their organizational members (Brink, 1998).

Unfortunately, although research confirms that news media are important source of health information for individuals (Freimuth, Greenberg, Dewitt, & Romano, 1984; Simpkins & Brenner, 1984; Wallack, 1990a), policy-makers (Weiss, 1974), and voters (Capella & Jamieson, 1994), few studies have explicitly investigated the effects of health news on viewers' perceptions of their own health, or their health

care organizations. Investigations of health care as a political issue (Capella & Jamieson, 1994) do not take into account personal effects of health news on health care consumers. From a communication perspective, it is important to examine the effects of mediated health messages on managed care members in their relationships with affiliates of managed care. The question guiding this investigation is the following: Do mass-mediated messages about managed care influence viewers' interactions within health care organizations?

In a discussion of the impact of mediated health news, Rowan (2000) recounts the story of a physician who spent considerable time at a party responding to concerns after a national news report on the high number of false positive results on mammogram tests. "Some party guests interpreted the news to mean that mammography was unreliable and that obtaining a mammogram was pointless. Others interpreted it cynically. Mammograms are money-making ventures for hospitals, they reasoned" (Rowan, 2000, p. 69). In this case, although the media report brought to light significant aspects related to an important women's health issue, the manner in which the story was reported left some viewers feeling confused and skeptical (Rowan, 2000).

Central to Rowan's (2000) concern about the role of the media in the dissemination of health information is the issue of source credibility in health news reporting. Especially specious, the increase in news coverage of health issues has caused a tremendous growth in health care public relations (Case, 1994). Pharmaceutical companies and physicians use the news media to disseminate information to potential patients. Health reporters are rarely trained in science or

statistics, making it difficult for them to accurately interpret information in scientific study findings. Rita Rubin, associate editor for *U. S. News and World Report* and a former reporter for the *Dallas Morning News* discusses the problematic nature of reporting health issues:

> Medicine is huge business these days and everybody's out to get as big a share of the pie as possible, and its really tough, especially if you're just starting out covering medicine, weeding through basically just what's really PR and what really is truly news (in Case, 1994, p. 15).

In addition to information about specific health issues, the media gives considerable attention to the financing and delivery of health care. American health care comprises almost one sixth of the Gross National Product in this country. Media are a primary channel for information about this important social and economic force (Grossberg, Wartella, & Whitney, 1998). Television and newspapers serve a "boundary crossing function" as they seek to "tell one institution, the public, about the workings of another" (Grossberg, Wartella, & Whitney, 1998, p. 84). In other words, health care as an institution is somewhat reliant on media to disseminate information, but this function also leads to the dissemination of negative stories about managed care.

A significant amount of media coverage is concerned with informing viewers about the relative strengths and weaknesses of managed care (Capella & Jamieson, 1994). As stakeholders in managed care organizations, viewers receive organizational messages from the media that they use to evaluate their own health care, and the

organizations to which they belong. Regarding the significant impact of this type of communication on organizational functioning, Wolvin and Coakley (1998) state:

> Effective communication is a major concern of business and industrial organizations throughout the nation. Internal communication of employees, managers, and executives, as well as external communication to an organization's publics, are important determinants of productivity and, thus, are considered to be crucial channels for accomplishing the mission of the organization (p. 1).

In recent years, components of managed care organizations have been the subject of a large amount of negative media attention (e.g., Noonan, 2000; Vergano, 2000). Patients' perceptions of managed care organizations are fueled by a lack of understanding about the implications of the often conflicting goals of cost-saving measures, and maximum health care for members (Morreim, 1997). "Aggressive, somewhat novel methods of cost control" include primary care physician gatekeeper systems (Morreim, 1997, p.35). In these systems, traditional care obligations of physicians are extended to include contractual financial requirements of the managed care organization. News reports inform audiences that doctors often make more money by denying needed care to patients (Morreim, 1997). As a result of reports such as these, patients who are managed care organizational members become frustrated, and perhaps cynical, toward their organizations.

A potential parallel to this phenomenon is documented in recent political communication literature that examines what Capella and Jamieson (1997) term "the spiral of cynicism" – an increase in cynicism brought on largely by the framing, or

selection and presentation style, of particular mediated political messages. Similarly, organizational scholars examine a cynicism trend in organizational culture brought on by a decrease in organizational trust due in part to media accounts of downsizing, mergers, and reengineering of corporate cultures (Deal & Kennedy, 1999; Dean et al., 1998). Organizational cynicism, brought on by mediated health messages, is the focus of this investigation.

The goal of this study is to examine various message frames found in news coverage of health issues to determine their effect on viewers' perceptions of healthcare organizations and institutions. Toward that end, three central areas of research will guide this investigation: (1) cynicism, including, both organizational and political cynicism, (2) framing, emanating from media agenda-setting research, and (3) health communication in organizational and mass mediated settings. Media effects research that examines the framing of news will be used to determine similarities between political issue coverage and health issue coverage by news media sources. Media-induced cynicism that is well-documented in mass communication and political communication research will be extended to explore the effects of increasing news coverage of health organizations and the healthcare system. Capella and Jamieson's (1997) "spiral of cynicism," created by strategic framing of news stories, will be used as a basis to examine the effect of mediated health information on health care consumers.

CHAPTER 2

Literature Review

O'Hair, Allman, and Moore (1996) describe the formulation of expectations about health care delivery through cognitive and affective processes. In the Relational Expectations Model (O'Hair et al., 1996), anticipated interactions are formulated through patients' cognitions concerning expectations of their physician, emotional memory, and existing belief structures. Cognitions emanating from media cues may lead managed care consumers to alter their belief structure concerning their managed care organization, thus leading to a sense of affective organizational cynicism. Before a further investigation of the specific nature of organizational cynicism, it is important to review extant research on the more general construct of cynicism.

Cynicism

Cynicism began in the ancient Greek town of Cynosarges as both a philosophy and a way of life. Original Cynics "held society's institutions in very low regard and expressed contempt for them in both words and actions" (Dean, et al., 1998, p. 342). Diogenes, exemplifying the archetypal cynic, was noted for carrying a lamp in daylight to help him locate one honest man. The historical view of the cynic is that of a lone figure, such as Diogenes. Today's cynic, however, is a collective figure. Sloterdijk (1987) asserts that "the discontent of our culture has assumed a new quality: It appears as a universal, diffuse cynicism" (p. 3). Defined simply, cynicism is "the universally widespread way in which enlightened people see to it that they are not taken for suckers" (Sloterdijk, 1987, p. 5). The tradition of American cynicism and distrust is manifested in the original government system of "checks and balances;"

however, cynicism has not constituted a major theme of mainstream political activity or, more importantly, has not been the primary source of public discussion until recent years (Cappella & Jamieson, 1997).

Public Cynicism

Cynicism, as a communication-related construct, has been the focus of scholarly inquiry in such areas as deception (e.g., Christie & Geis, 1972; O'Hair & Cody, 1991), political communication (Capella & Jamieson, 1997; Kaid, 1992;); mass communication (Noelle-Neumann, 1983); and most recently in the fields of health communication (Maibach & Flora, 1993) and organizational communication (Dean et al., 1998). Grossberg, Wartella, and Whitney (1998) define an institution as "any large scale entity embodying a range of social relationships and social functions, created by humans to perform an essential function for society. An institution, then, is a specific social organization where particular decisions are made and can be carried out" (p. 13). Capella and Jamieson (1997) describe the relationship between cynicism and the perceived breakdown of traditional institutions in America:

> Some attribute the breakdown of civil society to a corrosive individualism that has spawned what in earlier times would have been an oxymoron--the label 'private citizen'... It is axiomatic that the media are most influential in shaping our sense of the world in those areas where we have little direct experience, but high personal stakes (pp.27-28).

Although individuals have become less confident in institutions that previously guided society, there is an increase in personal responsibility to make decisions (Patterson, 1993). The media, as a source of information, seek to guide individuals but may also

confuse and/or distort complex issues. Some of the most complex and contradictory issues portrayed in the media are political issues.

Political cynicism, inextricably linked to perceptions of political disapprobation, alienation or inefficacy, continues to fuel the research of political scientists and communication scholars (e. g., Cappella & Jamieson, 1997; Miller, 1974). As early as the mid-seventies, survey data supported an atmosphere of discontent and alienation based on political events such as Watergate and the Vietnam War (Miller, 1974). Miller argues that "cynics to the left" seek social changes in the system to alter conditions or policies they find unfavorable, while "cynics to the right" tend to focus on the role of the individual in changing their own life. "Cynics to the right" (p. 962) are more likely to favor continuity in institutional systems. With almost exclusive attention paid to the rhetorical effects on the voter or the non-voter, extant research neglects the long-term impact on citizens outside the world of politics. Does media-induced cynicism concerning political issues expand to include a cynical perspective of other organizations and institutions?

Organizational Cynicism

In their review and conceptualization, Dean, et al. (1998) originate and define the concept of contemporary organizational cynicism as a negative attitude with three dimensions:

> (1) a belief that the organization lacks integrity; (2) negative affect toward the organization; and (3) tendencies to disparaging and critical behaviors toward the organization that are consistent with these beliefs and affect (p. 345).

Dean et al. (1998) describe theoretical predecessors to organizational cynicism that include five areas of cynicism research: personality approaches (Cook & Medley, 1954), societal/institutional focus (Kanter & Mirvis, 1989), occupational cynicism focus (Neiderhoffer, 1967; O'Connell, Holzman, & Armandi, 1986), employee cynicism focus (Andersson, 1996; Andersson & Bateman, 1997), and organizational change focus (Reichers, Wanous, & Austin, 1997; Vance, Brooks, & Tesluk, 1996; Wanous, Reichers, & Austin, 1994).

However, Dean et al. (1998) contend that their multidimensional conceptualization of organizational cynicism clearly differs from other cynicism research and existing organizational constructs in four aspects. First, organizational cynicism is a *state* as opposed to a *trait*. Whereas trait cynicism focuses on human nature (e.g., personality- or trait-based cynicism), organizational cynicism is based on particular organizational experiences that will most likely change over time. Second, organizational cynicism applies to all professions and is not relegated to a particular type of work. Third, the construct of organizational cynicism encompasses a tripartite framework of attitudes that includes affect as well as behavior and beliefs. Finally, the employing organization is the target of the cynicism.

This characterization of organizational cynicism as a tripartite phenomenon is comparable to Harquail's (1998) description of organizational identification. Harquail describes individuals' identification with an organizational structure to which they belong as a coupling of affective, behavioral, and cognitive elements. Moreover, Tajfel (1978) defines social identity as "the individual's knowledge that he belongs to certain social groups, together with some emotional and value significance to him of

that membership" (p.31). The importance of health and access to quality health care fosters the likelihood of some level of identification with an individuals' health care provider. The valence of this identification is affected by messages received in and about the organization itself.

Although the personal characteristic of cynicism is not highly regarded in today's society, organizational cynics often "act as the voice of conscience for the organization" (Dean et al., 1998, p. 347). Dean et al. (1998) note that currently, many employees express extremely negative attitudes toward their organizations. However, as a pervasive phenomenon in modern organizations, organizational cynicism should be viewed as neither "an unalloyed good nor an unalloyed evil for organizations" (Dean et al., 1998, p. 347).

Instead of a pessimistic, skeptical, or depressing organizational member, an organizational cynic may have higher self-efficacy in terms of their own health care. Self-efficacy for organizational cynics in managed care organizations may lead to "a necessary check on the temptation to place expediency over principle or the temptation to assume that self-interested or underhanded behavior will go undetected" (Dean et al., 1998, p. 347). Organizational cynics' beliefs, affect, and behavior serve as manifestations of their cynicism (Dean et al., 1998). However, these facets of organizational cynicism may also serve managed care members as means by which to participate in communication and decision-making related to their own health.

Beliefs. Beliefs related to organizational cynicism are described as a consumers' perceptions that the organization lacks integrity, honesty, fairness, and equality. Dean et al. (1998) characterize organizational cynicism as a belief that an

organization lacks integrity, or soundness of moral principle, especially in relation to truth and fairness. Organizational cynics believe that the organization operates primarily based on self-interest and greed and that organizational members are inconsistent and unreliable. In a model of patient cynicism, patients who have negative interactions with other organizational members (e.g., insurance, pharmaceutical companies, physicians) will experience an increase in their negative beliefs about the organization as a whole.

An example of this phenomenon is the Gallop Poll (2000) findings on public opinion about American institutions. The poll asked participants to rate their beliefs about institutions including banks, the U.S. Supreme Court, organized labor, television news, newspapers, the military, congress, the presidency, big business, police, the criminal justice system, and HMO's. Findings reveal participants have the least confidence in HMO's of all the institutions included on the survey. In addition, although HMO's have only been included on the annual survey of confidence in institutions since 1998, participants' overall confidence in HMO's has decreased every year. The American publics' lack of confidence in HMOs is one indicator of an overall belief system regarding managed care.

Affect. Unlike trait cynicism, organizational cynicism is an affective state. That is, it is felt as well as thought (Dean et al., 1998). Organizational cynicism is an emotional state and can include powerful emotional reactions such as sadness, fear, and anger toward their organization. Dean et al. (1998) observe that organizational cynics not only hold certain beliefs about their organization, but also have strong emotions tied to those beliefs. For example, in an article about the lack of coverage of

certain (usually expensive) pharmaceuticals, a 72-year old patient stated he sometimes skips taking his drugs to save money to pay for his wife's medications. He states, "It's stressful, and now it's scary. I don't want to see anybody else go through this " (Noonan, 2000, p. 24).

Behavior. Behavior of organizational cynics is manifested through expressions of lack of trust in the organization (Dean et al., 1998). Disparaging verbal behavior of patients might include explicit statements about lack of honesty, pessimistic remarks about the motives of the organization, or excessive probing concerning the veracity of other organizational members. Specific negative nonverbal behaviors associated with organizational cynicism include eye rolling, sneers, and smirks (Dean et al., 1998). Although these behaviors might not be performed in the presence of the physician, they may occur as a result of written communication, telephone conversations, or negative interpersonal interactions with managed care administrators. Behaviors of an organizational cynic might be in response to a lack of understanding about meaning, roles, and responsibilities of managed care.

Managed Care

Although health care providers are required by economic forces to be fairly well-informed about the intricacies of the changing health care system, a recent survey found that 55% of the American public are still confused about the true meaning of the term "managed care" (Health Care Advisory Board, 1996). Managed care organizations have five basic goals: risk management, provider selection, financial incentives for in-network utilization, quality assurance, and utilization review (Health Care Advisory Board, 1996).

Risk management refers to a decrease from traditional norms in the amount of assumed risk by insurance companies. Provider selection is the process of limiting patients' options when choosing a provider to those who contractually obligate themselves to the organization in terms of cost of care, quality of care, and geographic location. Financial incentives are used as barriers to encourage the use of selected providers based on the patients' out-of-pocket costs. Quality assurance is achieved through strict scrutiny of the providers' board certifications, outcome data, utilization patterns, and patient general satisfaction. Utilization review refers to the oversight process of selected providers.

For example, Dr. Linda Peeno, a former medical director, was responsible for approving or rejecting patient requests for health care. Peeno (1998) recounts her administrative experiences as a claims reviewer that eventually made her leave the field: "I became more compliant in the ways that counted: getting our numbers lower, cutting costs as much as possible, and denying everything we could" (p. 42). To combat these fears, industry experts urge, "a managed care organization that discloses its resource policies may win a large measure of trust from people otherwise cynical about the healthcare industry" (Morreim, 1997, p. 40).

According to a survey by U. S. News and the Kaiser Family Foundation (1998), three out of four Americans are concerned about their health care coverage in managed care organizations. The public is often disconcerted about managed care:

> One in six respondents has experienced delays in getting appointments. One fourth can't figure out their medical bills, and one in five has had problems paying them. Half of the respondents say they're worried that doctors are

basing treatment decisions strictly on what the health plan will cover (in Brink, 1998, p. 47).

These issues are compounded by media reports about the ineffective, unscrupulous, and even inhumane practices of some health care providers (e.g., Noonan, 2000). Actual experiences of patients serve as a basis for cynicism toward managed care. However, given the extensive media coverage of problematic managed care delivery, do the media create a picture of managed care that perpetuates and magnifies cynical beliefs, affect, and behavior? To understand the role of media in a potential rise in cynicism, it is important to explore the relationships between these two constructs.

Cynicism and the News Media

In a discussion of perceived cynicism in America, Capella and Jamieson state that the "American public is in a schizophrenic quandary over the principles that are valued, or should be valued, by our leaders, our institutions, and by our society" (1997 p. 4). Along with an increase in cynicism concerning American institutions in general, in recent years the amount of news coverage of health issues and health organizations has drastically increased.

News coverage of social issues affects perceptions regarding the scope of the issue, the relative advantage of potential solutions, and views of specific strategies and tactics used by activists and government officials in response to the issue (Gitlin, 1980). For example, the impact of news coverage of policy discussions regarding President Clinton's health plan was a trend toward increased coverage of political, economic, and social health issues (Capella & Jamieson, 1997). Gitlin states that the

more vivid and graphic the story, the more likely that it will be perceived as newsworthy. Exemplifying this argument, Case (1994) explains that often the best health stories are those that take a humanistic approach to medicine by exploring personal stories with a human angle.

Kinnick, Krugman, and Cameron (1996) discuss "the numbing of public concern toward social problems" based on the media's selective coverage of events. Their research finds that mass media are primary contributors toward a sense of emotional burnout about social issues (p. 687). Mass medias' emphasis on sensational, or bad news, have emotional consequences for viewers (Miller & Reese, 1982). "The bad news syndrome is exacerbated by a tendency of the media to present problems but not their solutions, contributing to feelings of inefficacy among media consumers (Kinnick, Krugman, &Cameron, 1996, p. 687). Edelman (1988) equates media-induced cynicism to a sense of powerlessness. Media viewers are subjected to an overwhelming quantity of conflicting information from a large variety of differing media sources. The manner in which news is presented to viewers, or the frame, is cited as the source of media induced political cynicism (Capella & Jamieson, 1997).

Prior to his retirement from the United States Senate, Senator Bill Bradley discussed the role of the media in the rise of collective cynicism. He noted, "the media tends to emphasize and encourage conflict. It exaggerates the sensational. Complexity is reduced to a sound bite...America is not as bad as it looks on the evening news" (Shaw, 1996, p. 14). The pervasive nature of media coverage such as this creates an omnipresent change in public opinion. Cynicism that may have begun as a response to

political issues, may now extend to a larger mistrust of other institutions that guide society, such as medical care providers.

Schramm and Porter (1982) estimated that in the 1920's, the average adult in the United States spent only three to four hours per day using the media (film, radio, books, newspapers), but with the advent of television, the time spent using media increased 40%. Americans spend most of their leisure time engaged in some type of mass media use (Robinson & Skill, 1995). Therefore, media influences our perceptions toward everyday events (Kellner, 1995). Johnson and Meischke (1993) state, "the public perceives the media to be the source of most of its health-related information" (p. 42). Wallack (1990) states that the media can serve as "a source of 'anti-health education,' presenting people with inaccurate or misleading health information through advertising, entertainment, and even news content" (p. 147).

Prior to an increase in news reporting of health issues, entertainment programming created images among viewers of the medical profession (Turow, 1991). Turow (1991) maintains that fictional television portrayals of the medical profession are one-dimensional and lack validity in many respects. Television medical programming portrays doctors: (a) only in traditional environments such as hospitals or doctors' offices, (b) as central characters in the delivery of often lifesaving care for patients, and (c) as primary care givers who work relatively independent of cost constraints or other organizational members. Similarly, Pfau, Mullen, and Garrow (1995) examined the influence of prime-time television viewing on public perception of physicians. Their findings suggest network depictions of physicians foster perceptions of doctors as interpersonally effective and physically attractive. However,

Pfau et al. (1995) found that physicians' perceptions of members of their own profession are more positive than fictional television depictions, which doctors felt were more negative, and exhibited less character and power than real physicians.

Wallack's (1990) contention that the media present inaccurate information about health care does not imply that doctors are the only profession being portrayed erroneously. Despite their central role in the delivery of health care, accurate portrayals of other health care professionals tend to be minimal in terms of media coverage in health news. For example, Buresh (1999) concludes: "Nurses are consistently overlooked in news coverage about health and health care" (online). Buresh (1999) conducted a study that analyzed direct quotes in stories about health care in the nations' top newspapers. Findings revealed that nurses were the "missing voices" in that "sources from government, business, education, nonprofits, even patients and family members as well as nonprofessional hospital workers were quoted more often than nurses" (in Buresh, 1999, online).

As a pervasive voice in the dissemination of perceptual information about health care professionals such as nurses, the media serve a primary function in creating a prevailing public opinion about the state of health care. Moreover, as a dominant perceptual force in public opinion about health care, the media's depictions of health care institutions serve to quell alternative views of reality.

Spiral of Silence

Noelle-Neumann (1973) posited the "spiral of silence" theory that offers an explanation for the domination of one opinion over all others in society. The establishment of a dominant opinion occurs as individuals look to mediated sources

for information on a topic. Noelle-Neumann (1973) argues that media, especially television, play a significant role as major sources of cues regarding opinion climate. Although media may not be powerful enough to alter individuals' opinions, media are potent enough to silence those who hold the minority opinion.

Once a majority opinion has been established and accepted, competing opinions are silenced. Noelle-Neumann (1973) contends that men, highly educated people, younger individuals and those with higher socioeconomic status tend to be more disposed to express their opinions and join conversations on controversial topics.

Although this theory suggests a macro-level phenomenon that could occur at the organizational level or in public opinion at large, the basis for the theory is Noelle-Neumann's (1973) description of the fear of isolation at the psychological level. Individuals holding the majority opinion feel at liberty to speak out on the topic. However, those who perceive their opinion on a topic to be in the minority tend to be silent on the issue for fear of social rejection. The fear of isolation refers less to the general public, and more to reference groups that individuals are attracted to and inclined to belong. The spiral of silence enlarges as those who perceive their opinion to be in the majority propagate the dominant theme, further suppressing those who perceive their views as being in the minority.

A crucial assumption in Noelle-Neumann's (1973) spiral of silence is that people make quasi-statistical judgments about which side of a controversial issue is ahead or "right," and which side is not well-supported, or "wrong." This theory describes a process in which the expansion of a collective worldview diminishes expression of alternative opinion. The spiral is a self-perpetuating, mutually

reinforcing, and pervasive process. Capella and Jamieson (1997) describe similar phenomenon to the spiral of silence as the "spiral of cynicism, " which also creates pervasive negative images based on media portrayals of issues.

Spiral of Cynicism

Capella and Jamieson's (1997) conception of the "spiral of cynicism" explores the relationship between particular frames on mediated messages and an icrease in cynicism among the American public. In regard to media's role in creating voter alienation and cynicism, Patterson (1994) uses the term "game schema" in which the media view politics as a game with winners and losers, with candidates on the "right" or "wrong" side of specific issues. Candidates make statements that allow them to get ahead in the race. The candidates are out to win, not make the country a better place to live. According to Patterson (1994), voter mistrust of the government increases and voter turnout decreases because the media portray election coverage as a game. Similarly, patients who are "losers" in the big game of health care are portrayed in the media as being in conflict with the "winners," or pharmaceutical companies, lawmakers, doctors, and especially insurance companies.

The spiral of cynicism (Capella & Jamieson, 1997) is a self-perpetuating, persuasive pull between "conflict-driven, sound-bite-oriented public discourse in the media and the conflict-saturated, strategy-oriented structure of press coverage" (p. 9). The conflict may be a struggle between political figures and the public, a conflict between managed care organizations and their members, or a pharmaceutical company and ailing patients. In all cases, the goal of the media is to provide interesting, ratings-oriented coverage of issues (Jeffries, 1997).

In an article entitled *Tuning in to Your Health*, Capella and Jamieson (1994) contend that the manner in which the media cover health issues affects public perception of the health care system in general. Common problems associated with the type of health news that is disseminated by the media are based in the framing of the health information (Wallack, Dorfman, Jernigan, & Themba, 1993). Framing research stems from the more general topic of agenda-setting. Managed care members do not exclusively receive organizational messages from their own health care organization. Instead, the media, through agenda-setting, helps shape (or frame) organizational issues for their members. Before an examination of the manner in which the media frames health information, a more general discussion of agenda-setting and framing is warranted.

Agenda-setting

Agenda-setting research is the umbrella under which the concept of framing has been explored. McCombs and Shaw's (1972) seminal work on agenda-setting combined content analysis of media coverage with public opinion research about issue salience. Cohen's (1963) work is cited as the genesis for Maxwell McCombs' initial interest and subsequent research program in the agenda-setting process (Rogers, Dearing & Bregman, 1993). Cohen created the expression often associated with agenda-setting when he observed that the press "may not be successful much of the time in telling its readers *what to think*, but it is stunningly successful in telling its readers *what to think about*" (p. 13, italics added). In this manner, health care consumers *think about* their own managed care organizations based on media messages they receive.

McCombs and Shaw (1993) assert that journalists' perspectives on the relative newsworthiness of a story are only one portion of the effect of news coverage on behavioral outcomes of audience members. Stories that are more vivid and dramatic are often deemed more newsworthy (Iyengar, 1991). "Agenda-setting is more than the classical assertion that the news tells us *what to think about.* The news also tells us *how to think about it.* Both the selection of objects for attention and the selection of frames for thinking about these objects are powerful agenda-setting roles" (McCombs & Shaw, 1993, p. 62, italics original). So, in effect, managed care members may also learn *how* to think about their organizations (i.e. cynically or efficaciously) based on media cues.

Kingdon (1984) discusses agenda-setting as the "stream" of possible issues that could be perceived as salient by policy makers, the public, and the media. Although Kingdon (1984) dismisses the media's ability to single-handedly put an issue on the agenda, he laments the significant impact of sensationalist news coverage of particular issues. Health issues are among those that Kingdon (1984) cites as being potentially ripe for sensationalism:

> One health respondent, for example, ridiculed the 'public fuss' over issues like saccharin or Medicare fraud, while more fundamental issues having to do with the economic or political structure of medical care were left relatively neglected. He complained, 'Deformed gnomes make quite an impression in front of the television cameras'" (p. 62).

In an article describing patterns of agenda-setting research, Kosicki (1993) defines agenda-setting as a process comprised of three subareas: public agenda-setting,

policy agenda-setting, and media agenda-setting (cf., Rogers & Dearing, 1988; Rogers, Dearing, & Chang, 1991). Public agenda-setting is concerned with the relationship between issues depicted in mass media content and the issue priorities of the public. Policy agenda-setting focuses on the issue agenda of public organizations or elected officials and their link to media content. Media agenda-setting research examines the "antecedents of media content relating to issue definition, selection, and emphasis" (Kosicki, 1993, p. 101).

Erbring, Goldenberg, and Miller's (1980) study introduces an "audience-effects model" that investigates media impact on issue salience. The importance of public issues is connected to media attention, especially when issue-specific audience sensitivities are used as modulators, and news coverage is used as a trigger stimulus. The audience-effects model is referred to as a comparable "mirror-image" model of media-effects (Erbring, Goldenberg, & Miller, 1980). In the audience-effects model, the manner in which a message is constructed, or framed, predicts specific outcomes from the audience.

Framing

In general, framing refers to the structuring of texts (e.g. Iyengar & Simon, 1993). Framing focuses on the manner in which communication influences individual cognitions by selectively highlighting particular parts of reality, while ignoring or downplaying other aspects (Entman, 1989; Entman, 1993; Gamson & Modialiani, 1989; Pan & Kosicki, 1993). This conception originates from converging theoretical ideas in sociology and psychology.

In an early description of the potential impact of framing, Cohen (1963) states, "The world will look different to different people, depending on the map that is drawn for them by writers, editors, and publishers of the press they read" (p. 13). Research on media framing and salience indicate that the media agenda does more than set the public agenda; it directs how people evaluate particular issues (Entman, 1989; Salwen & Matera, 1992). Moreover, the media agenda drives public opinion about the fundamental structure of institutions such as health care organizations.

Entman (1993) contends that journalists often lack a common understanding of framing, and consequently, media manipulators impose their dominant frames on the news: "Journalists may follow the rules for 'objective' reporting and yet convey a dominant framing of the news text that prevents most audience members from making a balanced assessment of a situation" (pp. 56-57). Powerful, dramatic stories often use strong frames to evoke emotion from viewers (Entman, 1993). Repetition of the theme of a frame is used to reinforce dominant ideas in a news story.

Rhoads (1997) advances that framing is a psychological device consisting of three components. First, a frame "offers perspective" in that it "manages the viewer's alignment in relation to the issue. Second, a frame "manipulates salience" because it "directs the viewer to consider certain features and ignore others." Finally, a frame "influences subsequent judgment" because it "precedes a persuasive attempt, and implies a certain organization for the information that follows" (Rhoads, 1997, online). "Significant framing effects have been demonstrated in experimental studies of choice and in survey studies concerning the effects of question wording on response patterns" (Iyengar, 1991, p. 11). However, most framing research centers on two

primary areas: (a) patterns of news coverage to identify characteristics of the news industry that foster the use of specific frames and, (b) alterations of news frames on political content that affect voters (Iyengar, 1991). Entman (1993) refers to framing as a research paradigm in which attention is given to "how a communicated text exerts its power" (p. 56). Framing is an extension of agenda-setting because framing provides a way to think about particular events:

> Frames, then, *define problems*—determine what a causal agent is doing with what costs and benefits, usually measured in terms of common cultural values; *diagnose causes*—identify the forces creating the problem; *make moral judgments*—evaluate causal agents and their effects; and *suggest remedies*—offer and justify treatments for the problems and predict their likely effects (Entman, 1993, p. 52, italics original).

Iyengar's (1991) experiments on agenda-setting provide an understanding of the process and implications of framing. Framing is the subtle process of selection by the media that highlights certain aspects of an issue to make them more important than other aspects of the same issue, thus emphasizing a particular cause of some phenomenon (Iyengar, 1991, p. 11). As a result, the media directs viewers toward a particular assessment of an issue through the use of framing.

Much of the sociological literature on framing focuses on the construction of news using the communicator and text as the primary units of analysis (Bateson, 1972; Gitlin, 1980; Goffman, 1974; Tuchman, 1978). Cappella and Jamieson (1997) observe that framing the news "is a question of slant, structure, emphasis, selection, word choice, and context" (p. 57). Within the realm of politics, research indicates that media

frames influence individual attitudes and judgments (Gamson, 1992; Iyengar, 1991; Iyengar & Simon, 1993; Zaller, 1992). Implicit in many of these studies is the perspective that media frames effectively control an issue's reality for audience members by including or excluding criteria that "create the meaning (or acceptable range of meaning) of an issue" (Ball-Rokeach & Rokeach, 1987, p. 184; cf., Bateson, 1972). However, Neuman, Just, and Crigler (1992) contend that individuals "do not slavishly follow the framing of issues presented in the mass media;" rather, people "actively filter, sort, and reorganize information in personally meaningful ways in constructing an understanding of public issues" (pp.76-77).

From a psychological perspective, Kahneman and Tversky (1983) examine the influence of cognitive "decision frames"--an individual's interpretation of the acts, consequences, and contingencies associated with a particular choice--on judgment and inference making. In experiments in which available choices were numerically equivalent but explanatory rationale was formulated differently, they found that while frames have common effects on large portions of the audience, the effects are mediated by individual norms and characteristics. This perspective is consistent with defining frames cognitively as a type of schema, script, or prototype; and as such contend that the presence of textual frames do not guarantee their influence on audience cognitions (Fiske & Taylor, 1991; Pan & Kosicki, 1991; Rumelhart & Ortony, 1977).

For example, some cognitive psychologists argue that individuals, when confronted with information, first locate the relevant attitude structure, or schema, to guide processing (Tourangeau, Rasinski, & D'Andrade, 1989). For those with well-

formed attitudes, the relevant schema is highly accessible (Bargh, 1988; Fazio, 1986; Higgins & King, 1981; Lau, 1982). However, with less familiar issues, no schema is readily activated, forcing a search for relevant schema (Petty & Cacioppo, 1984). Context helps identify the relevant cognitive structures, or scripts, to guide information processing (Abelson, 1981; Schank & Abelson, 1977). In this manner, cynicism concerning public institutions in general may be translated as a skeptical approach to physicians and healthcare institutions. Unfamiliar mass-mediated health issues may be considered based on cynical cognitive scripts created and reinforced by other mediated messages.

Price and Zaller (1993) found the extent to which an individual is more or less likely to become aware of particular news topics is directly related to their overall interest in public affairs. Prior knowledge acquisition affects the likelihood of future learning as schema are created and utilized to process information (Price & Zaller, 1993). Their findings suggest that, "Knowledge and media use are interdependent: better-informed people are both more likely to use the news media and more likely, by virtue of their stored information resources, to gain from that use" (p. 158). Additionally, Price and Zaller state that amounts of media use are not as predictive of news reception as prior knowledge.

Further, some theorists argue that since a recently used attitude structure is more accessible, schema activated by previous information may be used to process additional information encountered or serve as the criteria for comparison (Fazio, 1990; Higgins & King, 1981; Taylor & Fiske, 1978). This idea confirms that narrative media coverage of individuals' personal struggles to obtain excellent

healthcare could serve to form a more generalized attitude among viewers that the quality of their own healthcare is in question. If a media message serves as a warning for consumers to be better informed about healthcare, then that attitude is relevant for patients' interactions with their physicians, and other members of health organizations.

Tourangeau, Rasinski, and D'Andrade (1989) stress the role of context of mediated messages and argue that context has a tendency to trigger specific applications of a norm, which then provide the basis for ensuing judgments. A framework for linking media messages to individual cognitions has been suggested by Zaller (1992). He asserts that most people are internally conflicted with multiple, often opposing, considerations on important social issues. In research on attitude measurement, Zaller (1992) demonstrates that people do not systematically or exhaustively search all possible sources; instead, individuals sample from their available cognitions, oversampling those highly accessible or recently used. According to this perspective, the ordering or framing of textual materials activates certain considerations, that in turn guide the construction of attitudes (Bishop, Oldendick, & Tuchfarber, 1982; Zaller, 1992). This does not imply that textual messages determine individual attitudes, but that a person's predispositions interact with the encountered text, resulting in an attitude (Sniderman & Brody, 1977). Again, this suggests the possibility of an overarching, pervasive mediated cynicism if the number of negative media messages increases.

Self-efficacy and Framing

Drawing from the sociological and psychological perspectives, scholars have examined the relationship between media frames and individual cognitions (Lau, 1982, Shah & Domke, 1995). In experimental research on college students, Shah and Domke (1995) found that altering the textual frame of an issue influenced how viewers evaluated that issue, evaluated other issues within the environment, and subsequently used those evaluations in decision making. The influence of textual frames is conditional, based on which aspect of an individual's self-concept is activated during information processing (Shah & Domke, 1995). This research suggests the possibility that activation of cynicism could be based on personal traits such as self-efficacy. Therefore, it is important to examine links between textual frames and self-efficacy.

Bandura (1977) defines self-efficacy as an individual's belief in their ability to attain their goals. O'Hair, Friedrich, Wiemann, and Wiemann (1997) state that self-efficacy is almost always positively correlated with self-esteem. Bandura (1977) notes positive relationships between self-efficacy, control, and motivation. Finally, Berger (1983) discusses a positive relationship between self-esteem and interpersonal power.

Each of these correlates to self-efficacy play important roles in health care delivery as patients interact with doctors, nurses, hospitals, and insurance companies. For example, Beisecker (1990) found that role expectations in the physician-patient interaction are affected by perceived power. Also, O'Hair (1989) discussed the importance of control in physician-patient interactions. Finally, Klingle (1993)

underscored the importance of motivation in patient compliance-gaining efforts. While studies of interpersonal communication between patients and providers examine pre-existing cognitive structures that affect doctor–patient relationships, there is less research that examines how viewing media messages may interact with traits such as self-efficacy to affect health care interactions.

Ball-Rokeach and Rokeach (1987) found that media frames create meaning for viewers based on their existing cognitive structures. If self-efficacy is a primary factor in health consumers' motivation, self-esteem, and views of control and power in health care environments, then it is important to understand how cognitions related to self-efficacy interact with media message stimuli. Gerbner, Morgan, and Signorelli (1982) describe this as the need to explore the impact of "messages and images television as a whole discharges into the mainstream common consciousness" (p. 291).

As Ruben, Martin, Bruning, and Powers (1993) note, self-efficacy in health care interactions is often tied to patients' opinions about health care from sources outside their health care interactions. Mediated messages about health care may be just such an outside influence that affects viewers' beliefs about, and behavior in, the health care setting. Moreover, viewers' self-efficacy related to health care may create differential responses to media messages.

Bandura (1989) describes self-efficacy scales as measuring the perceived ability for task attainment. Since individuals locate the relevant attitude structures when confronted with specific tasks (Tourangeau, Rasinski, & D'Andrade, 1989), diminished self-efficacy could affect patients in the health care interactions by

influencing their perceived ability to attain quality care. In addition, attitude structures that may be altered by viewing mediated messages about health care could then work together to cause changes in beliefs, emotions, and behaviors in health care interactions.

A central question arises as to whether pre-existing self-efficacy levels affect behavior directly, or if the framing of textual messages activates responses that diminish perceived self-efficacy. Since there is no available evidence that framing causes diminished self-efficacy, the two constructs should be treated as separate potential predictors of organizational cynicism.

Framing, as a form of message structuring, potentially possesses the ability to activate components of organizational cynicism. There are specific types of frames that have differential cognitive, affective, and behavioral effects on viewers. These include thematic frames (Iyengar, 1991), strategic frames (Capella & Jamieson, 1997) and episodic frames (Iyengar, 1991).

Episodic Framing

Iyengar's (1987, 1991) research examined viewer's perceptions of causal and treatment responsibility, and found that television news presents stories as either "episodic" or "thematic" news frames. Episodic frames tend to be event-centered, specific, and concrete. They use powerful images to tell a direct, simple, and personal story. This type of frame results in the accentuation of personal responsibility for health issues (Iyengar, 1987). The individual in the narrative of the story is viewed as personally responsible and accountable for his or her health problems. "When television portrays the news in personal terms, psychological biases attributing

responsibility to individuals are activated and require the least cognitive work" (Cappella & Jamieson, 1997, p. 84).

Examples of episodic coverage include the plight of a homeless person or an adolescent drug addict, a murder attempt, or an airline bombing (Iyengar, 1991, p. 14). Cappella and Jamieson (1997) assert that "viewers exposed to episodic frames make relatively automatic trait inferences to the individuals portrayed and in so doing orient their attributions toward persons rather than situations" (p. 84).

A specific exemplar of episodic framing resulted from the Iyengar and Simon (1993) study that found that increased exposure to television news reports of the Gulf War crisis led to greater support for a military response, as opposed to a diplomatic response. These findings were in line with content analysis data of broadcast news reports of the Gulf crisis that revealed episodic coverage of the crisis, where each day viewers were offered another installment of the ongoing drama. The United States military, as opposed to diplomatic efforts, was most often highlighted in news reports. Since there is a great deal of research on the effect of framing of political news on viewers, it is important to assess possible effects of framing of health news. Health care, as an institution, serves a vital function for individuals in need of medical treatment. Like politics, health care is a personally and systemically important facet of society. As the amount of news coverage of managed care organizations increases, are viewers reacting to episodic, thematic, and strategic news frames in ways similar to their reaction to comparably framed political news? The goal of this project is to assess potential outcomes associated with the framing of health news content to gauge whether viewers recognize, and respond differently to various news frame types. In

addition, an exploration of the relationship between self-efficacy and organizational cynicism will help illuminate predictors of cynicism among organizational members.

Thematic Framing

Thematic frames are issue-oriented, general, and unapplied. Data and statistical information is most often reported with no humanistic narrative included. In terms of managed care, thematic framed news stories might include reports about general issues affecting society, as opposed to problems or concerns of one individual in one health care situation. Thematically framed news stories about managed care might include facts, statistics, and non-specific industry information.

Thematic frames present a collective view of an issue rather than the individual or personal story. They emphasize a societal responsibility for problems as opposed to an individual approach (Iyengar, 1991). Examples include reports on changes in welfare spending, congressional debates over the funding of employment training programs, the social or political grievances of terrorist groups, and the criminal justice backlog (Iyengar, 1991, p. 14).

Contrasting episodic and thematic frames, Iyengar (1991) explains that episodic frames emphasize "specific episodes, individual perpetrators, victims, or other actors at the expense of more general, thematic information" (p. 5) and portray "concrete events that illustrate issues while thematic framing presents collective or general evidence" (p. 14). Noting the essential visible difference between episodic and thematic framing, Iyengar (1991) underscores that "episodic reports make 'good pictures,' while thematic reports feature 'talking heads'" (p.14).

According to Iyengar (1991), "the greater the discrepancy between the attributions suggested by episodic or thematic framing and the viewer's predisposition, the weaker the influence of the news and vice versa" (p. 130). While strategic framing of political information is a major contributor to the collective spiral of cynicism (Cappella & Jamieson, 1997), strategic framing of health information may contribute to an increase in viewer cynicism about individual health care and perspectives of the health care system. Although thematic frames are utilized in mass mediated health news, the episodic frame is most common in the dissemination of health information (Wallack, 1990).

Strategic Framing

Similar to episodic news, strategic news draws the audience's attention to the motivations of the individuals portrayed. Strategic coverage focuses "squarely on winning and losing and the self-interest implied by this orientation, the traits activated are likely to be negative ones indicative of artifice, pandering, deceit, staging, and positioning for advantage—in general, mistrustfulness" (Cappella & Jamieson, 1997, pp. 84-85). In terms of managed care, this type story might include examples of a patient who has lost a battle for expensive or elective treatment against a managed care organization.

Strategic news, "encourages learning of strategic information, activate cynical attributions, and reinforce cynical political narratives" (p. 85). The long-term effects of strategic framing eventually cultivate the original cynicism attributed to political candidates into a more general cynicism about candidates, campaigns, policy debates, and government (Capella & Jamieson, 1994).

Rationale and Research Questions

The rise in cynicism is attributed to an increase in "horserace" style coverage of issues (Patterson, 1993). Each issue is presented to depict a winner, and implicitly, a loser. More often than not, the loser is the individual citizen, and the winner is an intimidating institution. If this type of framing affects viewers' perceptions of political institutions, does framing of health news affect health care consumers perceptions of health care as an institution, and of their own ability to attain good health care?

Kreps and Thornton (1992) define *health promotion* as "an important outcome of the use of strategic communication in health education efforts where individuals who acquire relevant health information use this information to take charge of their own health and make enlightened care choices" (p.197). The ways in which people acquire knowledge concerning health promotion often involve media use. According to McLuhan (1964), media are "extensions of man." Health promotion professionals are now able to reach more people in less time by using mass media as an educational tool. However, it is important to understand the impact of these mediated health messages on health care consumers' identification with managed care organizations.

Shah and Domke (1995) found that by modifying the textual framing of an issue, there was a change in how the text influenced viewers' evaluations of the issue, and how viewers subsequently were affected by those evaluations. Because framing has been shown to cause differential reactions among viewers, it is important to explore how framing of health news affects health care consumers. To examine responses of health care consumers, an examination of health news using

Iyengar's (1991) episodic and thematic frames, and Capella and Jamieson's (1997) strategic frames is warranted. These issues will be explored in research question one:

RQ1: What effect does the framing of health news have on viewers' levels of organizational cynicism?

Conversely, although individuals have become less confident in some major American institutions, perhaps there is an increase in personal responsibility to make decisions (Patterson, 1993). Does the role of self-efficacy increase in the absence of reliable organizational structures, credible leaders, or trusted institutions? Perhaps the ideal citizen that conforms to group participation has been transformed into a skeptical consumer who questions and distrusts the organizations and institutions that guide society. Does self-efficacy cause differential responses to media messages about health care institutions?

Narrative media coverage, such as that found in strategically framed stories of individuals' personal struggles to obtain health care, could serve to form a more generalized attitude among viewers that the quality of their own health care is in question. If the media message is a warning to be an informed consumer of healthcare, then that attitude is relevant for patients' interactions with their physicians. This phenomenon might be linked to a more educated health care consumer's level of perceived self-efficacy in health care environments. The following research question explores the potential interrelationship between self-efficacy among viewers' and varying message frame types:

RQ2: What effect does viewers' perceived self-efficacy have on their levels of organizational cynicism?

Neuman, Just, and Crigler (1992) contend that individuals "do not slavishly follow the framing of issues presented in the mass media;" rather, people "actively filter, sort, and reorganize information in personally meaningful ways in constructing an understanding of public issues" (pp.76-77). Therefore, it is important to explore potential causal outcomes related to viewing framed news stories. Does the framing of health news begin a causal chain involving cynicism, self-efficacy, or perceptions of managed care providers? The final research question explores predictive relationships among media frames, self-efficacy, and characteristics of organizational cynicism. Since Dean et al. (1998) define organizational cynicism as being comprised of beliefs, emotions, and behavioral tendencies, each of these factors will be explored in the following research question:

RQ3: Are there causal relationships among message frame types, self-efficacy, beliefs, emotions, and behavior related to managed care organizations?

CHAPTER 3

Method

Participants

Participants (n = 231) were undergraduate students enrolled in communication courses at a large Midwestern university. Students were recruited from the departmental research pool, and received course credit. Participants did not have to be members of managed care organizations since the goal of the project was to examine the effect of message frame types on *viewers'* levels of organizational cynicism. Participants acted as viewers of news content and responded to items assessing the three components of organizational cynicism described by Dean et al. (1998), including beliefs, emotions, and behavior related to managed care.

Participants ranged in age from 17 to 38 years old (M = 19.9, SD = 2.13). Eighty percent of the sample (n = 184) self-identified themselves as Caucasian, while 7.1% (n = 17) reported that they were African-American, 4.2% (n = 10) identified themselves as Asian-American, 3.8% (n = 9) were Native American, 2.5% (n = 6) Hispanic, and 2.1% (n = 5) reported being members of other ethnic groups.

Other demographic data revealed that 51.5% of participants were female (n = 119), while 48.5% were male (n = 112). Regarding classification in college, 37.9% (n = 91) of participants were freshmen, 32% sophomores (n = 77), 20% juniors (n = 48), and .8% seniors (n = 2). Two hundred and nineteen participants were single (91.3%), while six participants were married (2.5%). Although 76.7% of participants reported that they were insured through their parents' health insurance (n = 184), 69% stated they are members of a health maintenance organization (n = 153).

Design

A 2 (high self-efficacy/low self efficacy) X 4 (thematic frame, episodic frame, strategic frame, or control) independent group design was employed. The researcher randomly assigned each participant to one of four conditions in the experiment induction: thematic frame, episodic frame, strategic frame, or to the control group.

Procedures

Message creation. To control for potential differences in perceptions of the messages based on modality, each of the four conditions in the experiment utilized a video message format. The control group watched a brief video of commercials (non-health-related) taped from network television. Similar to the research design of Mitchell et al. (2001), simulated news broadcasts were created for the other three conditions of the experiment by enlisting the assistance of a health reporter from a local news station. Sarah Stewart, a reporter for the local NBC affiliate, acted as the anchor for the stories. The three message frame stories were shot using the local NBC newsroom as a backdrop.

A video production professional was enlisted to help generate an episodic frame story (see Appendix A) containing a narrative about one patient who died due to negligent care from a managed care organization. A thematic frame story (see Appendix B) was created that describes the same topic in a general manner, without specifically referencing one patient or incident. Finally, a third news broadcast segment (Appendix C) included language associated with a strategic frame such as depictions of winners, losers, and battles with managed care.

By using an actual set of a local news station, as well as a potentially recognizable reporter, perceived realism of the segments was enhanced. To control for potential biases related to participants' perceptions of the message source, one reporter was used to create all three stimuli videotapes. To control for potential topic biases, all of the framing conditions contained comparable story content.

Message pretests. Prior to conducting the experiment, each message was pre-tested to ensure it was perceived to exemplify a particular frame type. Participants in the pretest (n = 60) rated each segment by assessing the characteristics of the segment on thirteen Likert-type items. Items for the pretest (see Appendix D) were created using the definitions of episodic and thematic frames (Iyengar, 1992), and strategic frames (Capella and Jamieson, 1997). Each item asks the extent to which the health news segment matched the criteria set forth in the frame-type definition on a scale of one to seven (1 = Strongly disagree; 7 = strongly agree). All three scales were reliable (episodic frame scale $\alpha = .81$, thematic frame scale $\alpha = .82$, strategic frame scale $\alpha = .84$).

Results from the pretest were examined with the use of a one-way dependent ANOVA to assess differences in perceived message frame among the three pretest groups. Post hoc tests revealed that those participant who were exposed to the episodic news script ($n = 20$; $M = 5.22$, $SD = 1.11$) perceived it to be significantly more episodic (based on the definitional questions on the pretest instrument) than those who viewed the thematic ($n = 20$; $M = 3.20$, $SD = 1.05$), or strategic frame message ($n = 20$; $M = 3.12$, $SD = 1.12$) ($F(2, 58) = 26.32$, $p < .01$).

Similarly, those who viewed the strategic frame message perceived the story as significantly more strategic in nature (M = 5.51, SD = 1.29) than those who viewed the episodic (M = 3.93, SD = 1.01) or thematic frame news stories (M = 3.00, SD = 1.01; F(2, 58) = 53.26, p < .001). Finally, those pretest participants who viewed the thematic news frame story perceived it as significantly more thematic in nature (M = 5.34, SD = .97) than those who viewed the strategic frame story (M = 4.18, SD = 1.12) or episodic frame story (M = 2.90, SD = 1.02; F(2, 58) = 39.97, p < .01).

Induction. In this experiment participants watched a video in a classroom that acted as a laboratory for data collection. Prior to viewing the video, participants were asked to read and sign an informed consent, and complete some general demographic questions on the first page of the survey instrument. After viewing the videotaped news story for the randomly selected experimental condition, or the videotape of commercials viewed by the control group, participants completed the remainder of the survey instrument (Appendix E).

Instrumentation

Self-efficacy. (See Appendix E). This study used Woodruff and Cashman's (1993) generalized self-efficacy scale to measure participants' collective view of their own efficacy related to health. Moore (1997) reported an overall reliability for this scale of .87. In this study, the efficacy measure yielded a reliability of .92. The scale included 14 Likert-type questions tapping into participants' views of their own role in their health care. Items on this scale range from 1 (low perceived efficacy) to 7 (high perceived efficacy).

Perceived story frame. (See Appendix D). As an induction check, the survey included the same 13 items used in the message pretests to assess participants' perceptions of the frame of the news story viewed. Definitions of each frame type were used to construct questions assessing perceptions of strategy, thematic, and episodic frame content in the video segments. The control group did not complete this portion of the survey.

Four Likert-type questions assessed perceptions of the lack of or presence of a strategy frame; four Likert-type questions assessed perceptions of the lack of or presence of a thematic frame; five Likert-type questions assess perceptions of the lack of or presence of an episodic frame.

Components of Organizational Cynicism (Appendix E)

Beliefs. Dean et al. (1998) define beliefs related to organizational cynicism as perceptions that the organization lacks integrity, sound moral principle, honesty or integrity. To further explore the relationships between message frame types, self-efficacy, and beliefs about managed care, beliefs about specific components of managed care organizations were assessed. Besides patients, managed care organizations are generally comprised of physicians, nurses and other health care providers, hospitals, and insurance companies.

Beliefs about physicians. Five Likert-type items assess participants' perceptions of physicians (e.g. Doctors care more about patients than about profits, 1 = strongly disagree, 7 = strongly agree).

Beliefs about nurses. Five Likert-type items assess participants' perceptions of nurses and health care providers (1 = it is very rare for nurses and other health care

workers to care about the needs of patients; 7 = it is very common for nurses and other health care workers to care about the needs of patients).

Beliefs about hospitals. Five Likert-type items assess participants' perceptions of hospitals (1 = it is very rare to get good health care in a hospital; 7 = it is very common for hospitals to give patients the best possible health care).

Beliefs about insurance companies. Five Likert-type items assess participants' perceptions of insurance companies (e.g., Insurance companies work hard to meet the needs of the people they insure; 1= strongly disagree, 7 = strongly agree).

General beliefs about managed care. Five items assessed participants' beliefs about managed care organizations (e.g., Managed care is good for all patients; 1= strongly disagree, 7 = strongly agree)

Affect. Dean et al. (1998) define affect as a dimension of organizational cynicism in terms of emotional reactions to the attitude object, in this case managed care. Four discrete emotions potentially related to organizational cynicism were measured via a 16-item emotion scale (α = .92; Appendix E) previously utilized by Mitchell (2000). Perceived happiness, sadness, anger, and fear were measured via 16 Likert-type items that ranged from 1 (I feel none of this feeling) to 7 (I feel a great deal of this feeling). Example emotion statements included terms such as: dreary dismal, content, cheerful, enraged, furious, frightened, and panicky.

Behavior. Behavior related to organizational cynicism is defined as a tendency toward negative or disparaging behavior (Dean et al., 1998). This manifestation "indicates that cynical attitudes comprise tendencies toward certain types of behaviors, rather than specific behaviors" (Dean et al., 1998). Six Likert-type questions were

constructed from examples of organizational cynics' behavior in the Dean et al. study (e.g., "I will tell my friends and family that managed care is very bad for patients"). The behavior items were rated on a seven-point scale (1 = strongly disagree; 7 = strongly agree).

CHAPTER 4

Results

Independent Variables

The 2 X 4 factorial design of this study includes eight cells created from two independent variables. The first variable, message frame type, was divided into four levels: episodic message frame, thematic message frame, strategic frame message, and a control group. The second independent variable, self-efficacy, was divided into two levels (low self-efficacy and high self-efficacy) based on participants' responses to the self-efficacy scale (α = .92). The scale was assessed using confirmatory factor analysis for face validity, parallelism and internal consistency. All items were retained due to small errors (ranging from .02-.08).

To delineate low (n = 115) and high (n = 116) levels of self-efficacy among participants, descriptive statistics for this measure were computed to determine an appropriate median split (M = 4.95, SD = 1.34, Median = 5.25). Low and high efficacy groups were formed by comparing participants' self-efficacy composite score to the overall median for the scale.

Dependent Variables

Beliefs. Participants' beliefs regarding managed care organizations were assessed through questions about their beliefs about doctors, hospitals, health care practitioners, insurance companies, and general perceptions of managed care. As this measure was created specifically for this research project, three procedures were used to assess the reliability and validity of the

scale: exploratory factor analysis, confirmatory factor analysis, and Chronbach's alpha reliability analysis.

A Varimax rotation was used for the principal components analysis. Eigenvalues greater than 1.0 and a purity criterion of .60/.40 were used as the primary grounds for retaining items. That is, each retained item had a factor loading of at least .60 on its own factor, and no greater than .40 on any other factor. In cases where the principal components analysis and confirmatory factor analysis did not yield the same result, items were included or excluded from the final solution based on two considerations: the effect of item deletion on the reliability of the measure, and the theoretical rationale for the scale. Items were assessed to attain the highest possible reliabilities for each scale. Factors were assessed for inclusion based on their reliability and their heuristic value.

First, exploratory factor analysis (EFA) was performed on the 26-item Beliefs about Managed Care Scale (Table 1) to assess dimensionality of the measure. The principal components analysis yielded a four-factor solution that closely mirrored the original five subscales included in the scale. However, two original subscales, *beliefs about doctors* and *beliefs about nurses*, were collapsed into one factor. In addition, five items did not load adequately on any factor in the four-factor solution. These items were deleted from the final EFA solution.

The first factor in the principal components solution, *general beliefs about managed care*, includes five items assessing participants' general beliefs

about the utility of managed care. The second factor, *beliefs about healthcare professionals*, includes six items inquiring about participants' perceptions of doctors and nurses. A third factor was formed with five items related to *beliefs about hospitals*. Finally, the fourth factor includes five *beliefs about insurance companies* items.

Next, Confirmatory Factor Analysis (CFA) was performed on the five original subscales from the 26-item Perceptions of Managed Care Scale. The goal was to determine whether omitted items from the EFA harmed the internal consistency or parallelism of the scales. Also, the *beliefs about doctors* scale and the *beliefs about nurses* scale were assessed separately in the CFA analysis.

Similar to the EFA, the confirmatory factor analysis revealed that one item on the *general beliefs about managed care* ("Managed care is good for all patients") was not internally consistent with the other items. In addition, this item reduced the overall reliability of the measure and therefore was deleted. Subsequently, a five-item *general beliefs about managed care* subscale ($M = 3.49$, $SD = 1.15$, $\alpha = .90$), was retained as all items were internally consistent, and yielded errors no greater than .06. (Table 2).

One item on the *beliefs about doctors* subscale ("Being a doctor is very prestigious") was omitted from the CFA solution due to high error. Since this item was also omitted from the final EFA solution, the remaining four-item subscale was used for further analysis ($M = 4.54$, $SD = 1.03$, $\alpha = .80$). The

final *beliefs about doctors* measure was internally consistent and yielded errors no greater than .04 (Table 3).

Similarly, the five-item subscale assessing *beliefs about nurses* was deemed reliable and internally consistent (M = 4.49, SD = .97, α = .84). Although the EFA solution collapsed the *beliefs about doctors* and the *beliefs about nurses* subscales into one factor, a decision to assess these variables separately was made based on the significant amount of research that finds clear distinctions between patients' views of these two career fields (Bochner, 1983). The beliefs about nurses scale was internally consistent and yielded errors no greater than .05 (Table 4).

Table 5 displays the five items assessing *beliefs about hospitals.* These items created a subscale that was internally consistent, and yielded errors not greater than .06 (M = 4.15, SD = 1.13,α = .84). Finally, five items asked about participants' *beliefs about insurance companies* (Table 6). This subscale was highly reliable and yielded errors no greater than .09 (M = 3.18, SD = .99, α = .95).

Emotion. Four subscales included on the affect measure assessed participants' levels of *sadness* (M = 4.49, SD = 1.5, α = .94), *happiness* (M = 1.78, SD = .97, α = .94), *anger* (M = 4.81, 1.58, α = .94), and *fear* (M = 4.10, SD, 1.69, α = .94) after viewing the video induction. Exploratory factor analysis on the 17-item Emotions scale revealed a four-factor solution exactly consistent with the original scale (Table 7). Therefore, no items were deleted. Confirmatory factor analyses on the *Happy* scale (Table 8), the *Sad* scale

(Table 9), the *Anger* scale (Table 10), and the *Fear* scale (Table 11) each confirmed that the measures were internally consistent and yielded small errors, ranging from .00 -.14. Finally, the Chronbach's alpha reliability of the overall scale was high (α = .92).

Behavior. Six items measured participants anticipated behavior based on their reactions to the video message induction. EFA analysis revealed a three-item factor solution accounting for 76% of the variance, with an eigenvalue of 2.66. Reliability analysis confirmed the three-item measure yielded a higher reliability (M = 4.8, SD = 1.51,α = .85) without the additional three items. As three items do not constitute an over-identified scale, no confirmatory factor analysis was performed. The remaining three-item scale was used for further analysis (Table 12). Retained items include: "I would question my doctor about recommendations regarding my health," "I would seek out information about health issues from sources other than my health care provider," and "I would question all payment procedures of my managed care organization."

Manipulation Check

Prior to assessing differences in the three message frame scripts (Appendix A, B, C), reliabilities of the manipulation check scales were tested. In addition, principal components factor analysis (Table 13) and confirmatory factor analysis (Table 14, 15, 16) were performed to assess scales for internal consistency and parallelism.

Although the five-item episodic theme scale was reliable ($\alpha = .81$), item five did not load on any factor in the final factor solution of the exploratory factor analysis. Therefore, item five was deleted and a four-item episodic frame scale was retained ($\alpha = .82$). Both the thematic frame scale and the strategic frame scale were reliable (thematic frame scale $\alpha = .82$, strategic frame scale $\alpha = .84$), and all items loaded adequately on separate factors. Finally, all three manipulation check scales were assessed using Hunter and Hamilton's (1988) confirmatory factor analysis program and were determined to be internally consistent with small errors, ranging from .00 to .05 (Tables 14, 15, 16).

To ensure each of the three message frames were perceived differently by participants, one-way ANOVAs were performed on the manipulation check scales. All manipulations were successful, as significant differences were obtained among the groups on all messages. There was a significant difference between the three groups on the episodic frame scale ($F(2, 168) = 66.310$, $p < .001$, $\eta^2 = .44$). Games-Howell post hoc comparisons revealed that participants who viewed the episodic frame message scored significantly higher on the episodic frame scale ($M = 5.09$, $SD = 1.22$) than participants who viewed the thematic frame message ($M = 3.64$, $SD = 1.23$), or the strategic frame message ($M = 3.6$, $SD = 1.28$). In other words, those viewing the episodic frame message reported that the news story they viewed contained significantly more episodic message characteristics than those who viewed a thematic message or strategic message. Moreover, those viewing the strategic and thematic

messages perceived significantly less episodic message characteristics in the news story they viewed.

Similarly, there was a significant difference among the three groups on the thematic frame scale ($F(2, 168) = 88.69$, $p < .001$, $\eta^2 = .51$). Post-hoc comparisons revealed participants who viewed the thematic frame message scored significantly higher on the thematic frame scale ($M = 5.35$, $SD = 1.06$) than participants who viewed the episodic frame message ($M = 2.37$, $SD = 1.22$), or those viewing the strategic frame message ($M = 4.41$, $SD = 1.47$).

Finally, there was a significant difference among the three groups on the strategic frame scale ($F(2, 168) = 48.74$, $p < .001$, $\eta^2 = .37$). A Games-Howell post hoc test confirmed that participants who viewed the strategic frame message scored significantly higher on the strategic frame scale ($M = 5.25$, $SD = 1.03$) than viewers of either the episodic frame message ($M = 4.01$, $SD = 1.71$), or the thematic frame message ($M = 3.25$, $SD = .949$).

Research Questions One and Two

To assess research question one, *What effects do the framing of health news have on viewers' levels of organizational cynicism?* and research question two, *What effects do viewers' self-efficacy in health care interactions have on their levels of organizational cynicism?* two-way ANOVAs were performed on the dependent variables; beliefs, affect, and behavior. Table 13 displays the means for each of these variables.

Beliefs

Participants' responses to the Beliefs about Managed Care Scale were assessed to examine possible main effects for message frame type and self-efficacy, and any potential interaction effects from the two independent variables. Findings from this test reveal a significant main effect for message frame type ($F(3, 228) = 5.921$, $p < .001$, $\eta^2 = .07$). A post hoc multiple comparison procedure confirmed that participants who viewed the strategic message frame had significantly less positive beliefs about managed care ($M = 3.66$, $SD = .93$) than those who viewed the thematic frame message ($M = 4.16$, $SD = .93$), the episodic frame message ($M = 4.23$, $SD = .96$), or the control group (4.33, $SD = .68$). A main effect for the effect of self-efficacy on beliefs about managed care was also found ($F(1, 230) = 5.719$, $p < .05$, $\eta^2 = .03$). Inspection of the means revealed that participants with lower self-efficacy had significantly less positive beliefs of managed care organizations ($M = 3.95$, $SD = .89$) than those with higher self-efficacy ($M = 4.24$, $SD = .86$).

Finally, a significant interaction was found for message frame type and self-efficacy levels ($F(3, 228) = 3.148$, $p < .05$, $\eta^2 = .04$). The data confirm that participants with lower self-efficacy who viewed the strategic message frame had much more negative beliefs about managed care ($M = 3.27$, $SD = .96$) than any other group. In addition to the overall Beliefs about Managed Care scale, each subscale was assessed.

Beliefs about doctors. Although there was not a significant main effect for message frame type on perceptions of doctors (episodic $M = 4.58$, $SD =$

1.05; thematic M = 4.37, SD = 1.01; strategic M = 4.56, SD = .95; control M = 4.64, SD = .98), there was a significant main effect for efficacy level ($F(1, 230) = 13.97$, $p < .001$, $\eta^2 = .06$). An inspection of the means revealed that those with higher efficacy reported significantly higher perceptions of doctors (M = 4.81, SD = 1.09) than those with low efficacy (M = 4.27, SD = .97). No significant interaction was found.

Beliefs about insurance companies. A two-way ANOVA revealed a main effect for message frame type ($F (3, 228) = 3.43$, $p < .05$, $\eta^2 = .05$). A post hoc comparison confirmed that those in the thematic frame message group had significantly lower perceptions of insurance companies (M = 2.83, SD = 1.27) than the other message frame groups (episodic frame, M = 3.33, SD = 1.19; strategic frame, M = 3.41, SD = 1.21). Also, the control group had significantly higher perceptions of insurance companies than all three message frame groups (M = 3.7, SD = 1.1). No significant difference between low and high efficacy groups was found ($F(1, 230) = 2.24$, $p > .05$, n.s.).

Beliefs about hospitals. While there was no significant difference between the message frame type regarding perceptions of hospitals ($F(3, 228) = 1.56$, $p > .05$, n.s.), a significant main effect for efficacy was found ($F (1, 230) = 6.31$, $p < .05$, $\eta^2 = .08$). Those participants with higher efficacy reported significantly higher perceptions of hospitals (M = 4.56, SD = .94) than those with lower self-efficacy (M = 3.51, SD = 1.01). There was no significant interaction effect for efficacy and frame type ($F(1, 230) = .761$, $p > .05$, n.s.)

Beliefs about nurses. A main effect was found revealing participants' efficacy levels had a significant effect on their perceptions of nurses ($F(1, 230) = 6.63$, $p < .05$, $\eta^2 = .05$). Participants with lower levels of efficacy reported having lower perceptions of nurses ($M = 4.31$, $SD = 1.13$) than those with higher levels of efficacy ($M = 4.69$, $SD = .89$). However, neither a significant main effect for message frame type ($F(3, 228) = 2.27$, $p > .05$, n.s.), nor an interaction effect was found ($F(3, 228) = .221$, $p > .05$, n.s.).

General beliefs about managed care. This subscale measures general beliefs about managed care organizations, as part of the larger beliefs scale. Findings reveal there was a significant difference between the message frame groups in their perceptions of managed care ($F(3, 228) = 5.868$, $p < .01$, $\eta^2 = .07$). A Games-Howell post-hoc test revealed that those who viewed the strategic frame message had significantly lower perceptions of managed care ($M = 2.63$, $SD = 1.15$) than those who viewed the thematic frame message ($M = 3.47$, $SD = 1.4$), or the episodic frame ($M = 3.65$, $SD = 1.42$). Also, the control group had significantly more positive general beliefs about managed care than the three message frame groups ($M = 4.20$, $SD = .73$). No significant main effect for efficacy level ($F(1, 230) = 2.62$, $p > .05$, n.s.), or interaction ($F(3, 228) = 1.09$, $p > .05$, n.s.) was found.

Emotions

First, an overall emotion score was computed by creating a 17-item composite of the four emotion subscales (sad, happy, angry, scared). The four items assessing levels of happiness were reverse coded so that a higher number

on the overall emotion score indicated more sadness, anger, and fear, and less happiness.

A two-way ANOVA (message frame type x efficacy level) on overall emotion revealed a significant main effect for frame type ($F(3, 227) = 13.829$, $p < .001$, $\eta^2 = .17$), but no significant results were observed for either efficacy level ($F(1, 230 = .504$, $p > .05$, n.s.), or an interaction between the two independent variables ($F(3, 228) = .139$, $p > .05$, n.s.).

Regarding message frame type, a post-hoc test revealed both the thematic frame message group ($M = 3.49$, $SD = 1.09$) and the control group ($M = 3.39$, $SD = 1.08$) had mean scores that were significantly less than either the episodic frame group ($M = 5.11$, $SD = .98$), or the strategic frame group ($M = 4.62$, $SD = 1.21$).

This finding indicates that viewing general news stories focusing on factual information about managed care does not cause significantly more emotional response than not viewing such a message. However, both thematic messages and no message induction (control group) cause significantly less emotional response from the audience than episodic or strategic messages. Moreover, episodic messages including specific *visual* evidence of an individual's struggle with managed care (in interview format) did not cause significantly more or less emotional response from viewers than strategic messages, which only use inflammatory *verbal* messages. To further examine the effect of frame type and efficacy level on specific emotions, two-way ANOVAs were performed on each of the four emotion subscales.

Sadness. A main effect for frame type was found ($F(3, 227) = 8.19$, $p < .001$, $\eta^2 = .11$) revealing that those who viewed the episodic message frame story were significantly more sad ($M = 4.9$, $SD = 1.2$), and the control group was significantly less sad ($M = 3.35$, $SD = 1.32$), than those who viewed the thematic frame message ($M = 4.23$, $SD = .98$), the strategic frame message ($M = 4.26$, $SD = 1.1$). This may be due to the fact that the episodic frame message contained an emotional interview with a confederate, managed care patient who discussed the death of her father due to a decision by her managed care organization. Participants in the episodic frame group were likely responding to the sad nature of the story. No significant main effect for efficacy ($F(1, 230) = .504$, $p > .05$, n.s.), or interaction between the two independent variables ($F(3, 228) = .139$, $p > .05$, n.s.) was found.

Happiness. There was no significant difference between the three message frame groups for level of happiness after viewing the video. However, the control group was significantly happier than all three treatment conditions ($F(3, 227) = 27.70$, $p < .001$ $\eta^2 = .30$). The control group ($M = 3.6$, $SD = 1.18$) was substantially happier than the group viewing the episodic frame message ($M = 1.63$, $SD = .89$), the thematic frame message ($M = 1.76$, $SD = 1.15$), or the strategic frame message ($M = 2.08$, $SD = 1.05$).

This finding indicates that viewers are negatively affected by news stories depicting negative messages and images about managed care, and partially supports the finding for the sadness variable, where the control group was significantly less sad than the three treatment conditions. No main effect

for efficacy ($F(1, 230) = .086$, $p > .05$, n.s.), or interaction effect was found ($F(3, 228) = .197$, $p > .05$, n.s.).

Fear. Findings from the fear subscale revealed a significant main effect for message frame type ($F(3, 228) = 2.812$, $p < .05$, $\eta^2 = .05$). A post hoc test confirmed that the control group was significantly less fearful ($M = 2.86$, $SD = 1.57$) than any of the three treatment groups (episodic: $M = 3.88$, $SD = 1.73$; thematic: $M = 4.06$, $SD = 1.61$; strategic: $M = 3.93$, $SD = 1.79$). These data confirm that viewing news stories with negative content about managed care organizations make viewers more fearful about potential interactions with managed care organizations. No main effect for efficacy level ($F(3, 228) = .235$, $p > .05$, n.s.) or interaction effect was found ($F(3, 228) = .962$, $p > .05$, n.s.)

Anger. Results from a two-way ANOVA revealed a main effect for anger among participants ($F(3, 228) = 8.959$, $p < .001$, $\eta^2 = .14$). A post hoc test confirmed that that the control group was significantly less angry ($M = 3.32$, $SD = 1.47$) than the episodic message frame group ($M = 5.00$, $SD = 1.45$), the thematic message frame group ($M = 4.83$, $SD = 1.65$), or the strategic frame group ($M = 4.60$, $SD = 1.74$).

Similar to the results from the fear measure, these data seem to indicate that exposure to health news stories containing negative information about managed care does create an emotional response from viewers. This emotional response does not seem to be related to viewers' levels of self-efficacy, as no main effects for efficacy ($F(3, 230) = .504$, $p > .05$, n.s.), nor a significant

interaction for efficacy level and frame type ($F(3, 228) = .139$, $p > .05$, n.s.) was found.

Behavior

There was no significant difference between the frame type groups for behavior ($F(3,228) = 2.07$, $p > .05$, n.s.), but a main effect for efficacy level was found ($F(1, 230) = 10.64$, $p < .001$, $\eta^2 = .06$). Inspection of the means revealed that participants with higher self-efficacy levels were more likely than those with low efficacy levels to engage in proactive behavior in health care interactions (high efficacy: $M = 3.82$, $SD = 1.62$; low efficacy: $M = 2.69$, $SD = 1.73$). No significant interaction effect was found ($F(3, 228) = .785$, $p > .05$, n.s.).

Research Question Three

Finally, to assess potential causal relationships among message frame types, self-efficacy, beliefs about managed care, emotions, and health care behavior, a path model was tested. To achieve this, correlations among the variables were first examined (Table 18).

The model was originally constructed utilizing message frame type and efficacy level as the two exogenous predictors of beliefs, with beliefs mediating the relationships between emotion and behavior. However, the first proposed model (Figure 1) yielded high errors in some causal links. Therefore, an amended path model was constructed based on face validity and the results from this study (Figure 2).

The fit of the final path model (See Figure 2) was supported by two observations. First, the size of the path coefficients was substantial. Second, the differences between the predicted and obtained correlations were insubstantial, and the path model is consistent with the data ($\chi 2$ (2) = 3.48, p > .05).

CHAPTER 5

Discussion

The purpose of this study was to examine the effects of health news and self-efficacy on viewers' perceptions of managed care. Dean et al. (1998) define organizational cynicism as being comprised of three elements: beliefs about the organization, emotion as a response to messages about the organization, and behavior in interactions with others in the organization. In terms of managed care, beliefs might be related to the entire health care organization, or might be specifically tied to one component of managed care such as doctors, nurses, hospitals, or insurance companies. Each of these beliefs was assessed in this project.

Emotional responses to mediated messages about managed care were also assessed. Since organizational cynicism is described by Dean et al. (1998) as a negative state, specific emotions related to cynicism including anger, sadness, and fear were assessed. In addition, happiness was measured to contrast with the three negative emotions.

Finally, perceived possible behavior in response to mediated messages about managed care was measured to examine potential differences based on viewers own level of self-efficacy in health care interactions, and based on the message frame present in the news story. Viewers inclined toward organizational cynicism might be more proactive in their interactions with managed care components such as doctors, nurses, insurance companies, or

hospitals. Similarly, those viewers with higher levels of self-efficacy might also be more proactive in their health care interactions.

Research Question One

Research question one examined the effects of health news message frames on viewers' levels of organizational cynicism. These data revealed several interesting results. Regarding beliefs about managed care, participants viewing the thematic news frame reported significantly less positive beliefs about insurance companies than the strategic or thematic frame groups. Also, participants viewing the strategic news frame reported significantly less positive beliefs about managed care.

Since all three news stories centered on payment for a health care procedure, those in the thematic group may have been attributing the negative aspects of the story to the insurance component of managed care, instead of doctors, nurses, or hospitals, who were not specifically mentioned in the story. This rationale would imply that those in the thematic group were more cognitively processing specifics of the story than the strategic message group or the episodic message group. A potential reason for this lack of processing is the emotional state of participants.

Among the three frame types, the thematic frame elicited the least overall emotion from viewers. This might be expected since the thematic frame message did not contain inflammatory and/or confrontational language found in the strategic news frame (e.g., "winners," "losers," "battle," "fight"...). Unlike the episodic frame, the thematic frame message did not include the

specific details of a patient who died due to a managed care policy. Therefore, the content of the thematic frame message was more generic, and less emotionally pervasive, than the other two message frames.

Because participants in the thematic group were both less emotional and had less positive beliefs about insurance companies than either of the two treatment groups, these data imply that viewing general, non-inflammatory messages about managed care, resulted in more cognitive processing about the actual content of the message due to the absence of a heightened emotional state.

However, as no differences were found in the behavior scores of the three groups, it is questionable whether the negative beliefs about insurance companies would translate into behavior in a managed care organization. Thus, organizational cynicism would be manifested in beliefs and emotions, but those two facets of cynicism might not affect individuals' interactions in the health care environment.

Conversely, those participants in the strategic message group reported less positive beliefs about managed care than either the thematic message group or the episodic message group. The strategic message group viewed a version of the story that included more inflammatory language about managed care than the other two frames. Therefore, it would follow that they might feel more angry than the other two groups. Results revealed that although there was no significant difference between the means of the three groups regarding

anger, the strategic group did in fact report feeling more angry after viewing the story than either the thematic group or the episodic group.

The strategic group also scored significantly higher on the behavior measure than the other groups. That is, the strategic group stated they would be more likely to question recommendations about health care, seek out health care information from secondary sources other than their primary provider, and question payment procedures of a managed care organization.

Finally, although the episodic group did not report any significantly positive or negative beliefs about managed care organizations, they did report being significantly more sad than the other two groups. The episodic frame message included an interview with a woman whose father recently died. It is logical that participants viewing the episodic frame message were more sad than those who viewed the thematic frame message or the strategic frame message.

An examination of results from the beliefs, behavior, and emotion variables for the three message frame types may indicate that negative state relief trend is present (e.g., see Baumann, Cialdini, & Kendrick, 1981). Cialdini's Negative State Relief Model postulates that when a message evokes an emotional response, cognitive processing of the message is diminished as the individual deals with their emotional state.

In this study, the thematic group was less emotional, and therefore focused attention on the specific villain portrayed in the message, the insurance company. The strategic group was slightly more angry than the other two

groups, but significantly more prone to proactive behavior to guard against potential mistreatment by managed care. Their perceptions of managed care, as a general construct, were significantly less positive than the thematic or episodic frame groups. The strategic group sought to deal with their negative view of managed care through more proactive behavior in their own health care interactions. The episodic group, who was significantly more sad than the other groups, did not report significantly different beliefs or behaviors. Their negative emotional state overshadowed any specific cognitive processing of beliefs or behavior about managed care.

These findings extend Dean et al.'s (1998) description of organizational cynicism by characterizing the effects of the framing of messages about an organization on those exposed to the message. It is clear that beliefs, emotions, and behaviors related to organizational cynicism are directly linked to the type of organizational message presented.

General messages, such as the thematic frame, seem to cause a significantly less emotional or behavioral response, but more cognitive processing about the specifics of the message. That, in turn, causes a diminished view of the organizational component that is the subject of the message.

Episodic messages, or those that contain specific information about individuals who have suffered from potential wrongdoing by the organization, cause those exposed to the message to feel more sadness in response to the

message than other frame types. However, this sadness does not appear to translate to any specific beliefs or behavior.

Strategic messages, or those that describe organizations and their members as adversaries in a battle, evoke more proactive behavior toward the organization. Strategic messages also create a less positive belief about the organization as a whole, without regard to any specific component who might be the source of a problem or issue.

Research Question Two

Research question two examines the effects of viewers' perceived self-efficacy on their beliefs, emotions, and behavioral responses to mediated messages about health care organizations. Self-efficacy is defined as a perceived ability to execute behaviors successfully in order to achieve specific goals (Woodruff & Cashman, 1993). The goal of this investigation was to examine how self-efficacy affects the manifestations of organization cynicism, and to examine potential interactions with self-efficacy and message frame types. Although perceived efficacy did not significantly affect any of the emotion variables, there were significant results regarding beliefs about managed care and behavior in health care interactions.

First, results reveal that participants who reported higher levels of self-efficacy had significantly more positive beliefs about managed care, doctors, nurses, and hospitals. This finding suggests that those with higher efficacy see health care providers as allies in their efforts to gain quality care. Conversely, those with lower levels of perceived efficacy were less confident about the

roles of managed care, doctors, nurses, and hospitals in the delivery of their health care.

These findings suggest that low self-efficacy affects organizational cynicism since those who do not feel competent to execute behaviors to achieve their own health care goals may believe that agents of the managed care organizations (doctors, hospitals, nurses etc.) act as barriers to their achievement of their goals. Therefore, lower efficacy individuals' beliefs about doctors, hospitals, nurses, and managed care organizations are less positive than those with higher perceived efficacy. In turn, low self-efficacy individuals behave less proactively in health care interactions.

Second, there was a significant difference between the projected behavior of the low and high self-efficacy groups. Those with higher self-efficacy reported they were more likely to be proactive in their own health care, while those with lower efficacy were less likely to question doctors decisions, seek out health information from secondary sources, or question payment procedures of a managed care organization. Woodruff and Cashman (1993) describe how self-efficacy is the perceived ability to execute behaviors to meet individual goals. Therefore, it is logical that efficacy would play a major role in behavioral decisions among participants since by Woodruff and Cashman's definition, self-efficacy includes a behavioral dimension.

Research Question Three

Results from research question three provide support for the idea that framing and self-efficacy play two distinct roles in the manifestations of

organizational cynicism. First, the correlation between message frame type and self-efficacy level was not significant ($r = -.04$). Second, since no significant differences were found between low and high efficacy groups regarding emotion and the correlation between these two variables was small ($r = .01$), no causal link was placed in the path model between these two constructs.

However, since existing literature and results from this study revealed differences in beliefs and behavior based on self-efficacy levels, the path does include this causal chain. The path confirms that although the correlation between self-efficacy and beliefs is positive ($r = .31$, $p < .01$) beliefs about managed care moderates the relationship between efficacy and behavior.

In terms of organizational cynicism, this means that behavior in health care interactions is affected by existing cognitive structures about managed care. The positive relationship between self-efficacy and beliefs indicates that as individuals' levels of self-efficacy increase, they have more positive beliefs about managed care providers. Similarly, the positive relationship between beliefs and behavior indicates that more positive beliefs translate to more proactive health behaviors. The causal link among the three variables helps clarify how cognitive attributes lead to more or less, cynical behavior.

Unlike self-efficacy, message frame types were revealed to significantly affect both beliefs and emotions among participants. The path model includes message frame type as an endogenous variable, driving participants' emotions and beliefs about managed care. Moreover, the causal chain reveals that both beliefs and emotions activated by message frame types

affect behavior in managed care interactions. Beliefs and emotions act as moderators for participants' anticipated behaviors when dealing with managed care component groups.

Finally, a significant interaction between self-efficacy and message frame type found in the two-way ANOVA examining participants' beliefs about managed care was confirmed by the path diagram. Both efficacy level and message frame type worked together to affect participants' beliefs about managed care. Practical implications from this finding suggest that although managed care groups should be aware of the framing of news content about health care delivery, perceived self-efficacy of potential patients also plays a significant role in the manifestation of organizational cynicism. It is likely that patients who do not feel efficacious in their health care organization may opt out if given the opportunity to change their insurance coverage.

Managed care groups wishing to avoid or diminish the possibility of cynicism within the organization should work to provide members with appropriate avenues for goal attainment to increase the possibility for perceived self-efficacy. This might mean creating open channels for communication between patients and managed care administrators, forging relationships with doctors who listen and interact proficiently with patients, or demystifying procedures for payment of health care claims. While it is not likely that the framing of health news content can be controlled by managed care groups, steps can be taken to alter patients' self-efficacy levels. Since efficacy drives beliefs and behavior in the path model, it is important for

managed care organizations to consider options to positively influence patients' beliefs about their health care to avoid cynical behavioral responses. *Managed care* must consider the importance of *managed messages* about their organizations in mass communication, organizational communication, and interpersonal communication environments.

From a mass communication perspective, the amount of health news coverage is a trend that continues to grow every year (Noonan, 2000). Although some argue that news coverage is biased against doctors and managed care groups (e.g. Morreim, 1998) others have tried to use the media to gain positive exposure for health care initiatives (Case, 1994). Health care, as an institutional structure, must strive to provide consumers with clear, open, and honest information through mass mediated channels. This may mean offering additional training for health reporters on topics such as statistics, medical jargon, and treatment protocols. Not offering training for reporters expands the possibility of confusing, contradictory, or erroneous reporting on health topics. Without appropriate training, press releases from pharmaceutical companies and physicians will continue to be treated as news (Case, 1994) instead of public relations efforts. Without well-informed reporters, the likelihood of gaining a well-informed public diminishes. Two-way communication between doctors and media sources may foster improved understanding of the growing interdependence between health care and the media.

From an organizational perspective, health care professionals must increase communication among themselves. Just as television and newspapers learn about each other through reports on the problems and issues with one another (Grossberg, Wartella, & Whitney, 1998), health care professionals often learn about issues in their own field from the media (Case, 1994). Negative stories about managed care might be combated through effective communication efforts within managed care groups. If managed care organizations are centrally concerned with goals related to the financing and delivery of health care (Health Care Advisory board, 1996), then organizational members should be well-informed about the most effective methods to achieve these goals.

Finally, there is a large body of research examining the importance of the physician-patient interaction (e.g., see Thompson, 1995). From a micro perspective, managed care could potentially weather negative media attention from health news sources as long as patients have strong interpersonal relationships with their primary care providers. Political scientists found that although individuals in the 1990's did not feel favorably toward Congress as an institution, many voters still approved of their own representatives. Similarly, although health care as an institution might not be viewed in a positive light, patients' positive relationships with their own health care providers could reduce the impact of organizational cynicism. In other words, even if beliefs, emotions, and behavioral tendencies concerning managed care are temporarily affected by media reports, positive long-term relationships

with physicians could encourage patients' feelings of self-efficacy in their own health care delivery.

Conclusion

This study extends Dean et al.'s conceptualization of the three aspects organizational cynicism, beliefs, emotion, and behavior. This is achieved through an application of their ideas regarding organizational cynicism to the managed care environment. Dean et al. (1998) present a theoretical argument for the potentially detrimental construct of organizational cynicism. Although their study establishes a strong rationale for state cynicism that is uniquely different than the much studied trait cynicism, their research did not include any tests of the proposed construct.

Organizational cynicism toward managed care organizations proved to be a potent outcome for viewers of negative messages. Further, the framing of those messages affected viewers' perceptions of the organization. Beliefs, emotions, and behaviors were altered by negative message stimuli. The type of message viewed by participants affected their cognitive and behavioral intentions for future health care interactions.

In addition, participants' confirmed that self-efficacy is an important predictor of some aspects of organizational cynicism. Although the emotional aspects of cynicism were not affected by participants' efficacy levels, beliefs about managed care and potential behavior in health care interactions were altered based on efficacy levels.

Limitations and Future Research

An obvious limitation of this study is that participants were undergraduates who were not necessarily members of managed care groups. This limitation has several important implications for this study. First, the ability to generalize the study to actual managed care organizational members' is diminished. However, since participants in the treatment groups all viewed the message stimuli, they acted as surrogates for managed care members who might view similar messages. Future research should apply Dean et al.'s (1998) conception of organizational cynicism to actual organizational members. This would provide much more valid data regarding the existence of this construct.

Another problem related to the college sample was the high scores on the self-efficacy measure (M = 5.25). Since college students do not typically have extensive experience with the financing and procurement of their own health care, participants' were likely more efficacious than those who have experienced barriers to health care such as cost and managed care regulations. Individuals who have been responsible for health care decisions are probably somewhat different in their efficacy levels regarding health care than those whose parents have taken care of those issues for them. College students are at the beginning of their adult lives, and therefore have not usually experienced the responsibilities associated with health care decisions and payment.

Related to the first limitation, participants were asked to respond to emotion and behavioral items based on how they would feel and/or act if they were members of managed care organizations. Self-report data on anticipated

feeling and behavior may not be representative of the actual responses managed care members would experience after viewing the mediated messages. It is likely that viewers' level of involvement with the message topic is positively related to their level of emotion and/or behavioral intentions. Therefore, accurate emotional and behavioral responses could not be attained from non-members of an actual organizational structure.

Next, despite the fairly large sample, effect sizes for many of the significance tests were very small. This problem increases the likelihood for Type I errors. In addition, significant differences for small effect sizes may be attributed to sampling error. However, as Schmidt (1996) and others have noted, considerable problems with significance tests such as their low power often lead to Type II errors. Given the low power associated with significance tests, any findings that do yield statistical significance should be reported. Moreover those approaching a statistically significant level are also worth noting.

A large body of literature chronicles the effects of media on viewers. Because of this, it is virtually implausible to believe the specific media messages examined in this study to have no effect on viewers. Therefore, the null hypothesis that the message frame stimuli had no effect on participants is not a likely conclusion. Type I error may be present in this study, but as an initial investigation of media effects on viewers' of health news, this study begins a dialogue about the nature of responses to health news by viewers. Also, since this study is a first look at differences between viewers' levels of

organizational cynicism based on mediated messages, it would be impossible to have conducted more comprehensive procedures such as meta-analysis. To add to a body of research on organizational cynicism in applied contexts, mean scores, standard deviations, and effect sizes were reported for future potential investigations using meta-analysis.

Finally, measures of cognitive processing were limited in this study. Future research should examine how various message frame types are processed to confirm whether emotion diminishes cognitive processing of specific message content. This could be accomplished by assessing recall of details of the message, and assessing how those details are related to message framing. This would allow for clear relationships among frame type and cognitive processing to be assessed.

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Appendix A
Episodic News Frame

(anchor)

The family of Oklahoma City resident Donald Payton is suing Kaiser Permanente for wrongful death of their loved one. Payton's family claims that the managed care organization denied Payton's request for a specialist to perform a surgical procedure for his rare form of cancer. The 43 year-old Payton was diagnosed with a rare form of brain cancer late last year.

Given only a 2-5% chance of surviving without proper treatment, Payton's doctor informed him that he had an excellent chance of full recovery if he would undergo an experimental procedure that included surgery to cut the cancer from his brain stem. When Payton contacted his managed care provider, Kaiser Permanente, he was informed by the insurance company that there were no surgeons in their organization who had ever performed the necessary procedure. Instead, Kaiser recommended Payton visit a surgeon who ***was*** a member of the managed care group.

According to Payton's family, a representative of Kaiser Permanente told Payton that if he went to **any** doctor other than the **recommended surgeon**, Kaiser would not pay for the surgery. Unfortunately, Payton *did* go to the recommended surgeon, but he died on the operating table. Payton's daughter Ashley says that Kaiser Permanente is solely responsible for the death of her father. She says a general surgeon was not prepared or experienced enough to operate on her father.

(cut to daughter – do not read this section)

"My dad died because Kaiser Permanente was trying to save money. If he could have gone to any of the four doctors in Oklahoma City who have experience with this kind of surgery, he would probably be here today. But he was sent to a heart doctor with no experience doing brain surgery. Sometimes I think Kaiser forgets that their members are real people. It's hard to believe that they care more about profits than patients like my dad. They didn't deny his surgery, but they spent a whole lot of money to let an incompetent doctor kill my father.

(Cut back to anchor – read this section)

Ashley Payton and her family are suing for an unspecified amount in damages.

Appendix B
Thematic News Frame

(anchor)

In our health watch tonight, there is some concern in Oklahoma City tonight over what many are calling an accident waiting to happen. Several healthcare citizens groups are criticizing the common practice of managed care organizations, who require their patients to only see doctor's who are part of a specific health care network. The concern is that patients who need of treatment from ***specialists*** are being denied care because their managed care organization doesn't have a contract with a particular physician. It has been reported that some patients who are members of managed care groups have **even died** from lack of proper treatment from a specialist.

The healthcare citizens groups raise this concern about patients access to qualified doctors in response to a report that found over **60%** of Americans are now members of managed care organizations. The fear is that as the number of managed care members increases, there will be more and more patients who **are denied necessary treatment** from their managed care organization, due to **financial agreements** between doctors and insurance companies.

Appendix C
Strategic News Frame

(anchor)

In our health watch, there is a huge dispute brewing tonight in Oklahoma City over what many are calling a losing battle for healthcare patients. A healthcare watchdog group filed suit today in civil court criticizing what they claim is an attack on patients' rights by managed care organizations. The major concern is that patients are **losing their battle** to visit doctors who are specialists in the treatment of rare conditions. Also of concern is the claim that managed care organizations are denying patients' requests to see specialists as part of an overall cost-saving strategy.

It has been argued that managed care organizations are using **unfair tactics** to avoid payment for expensive operations.

The citizens watchdog group claims that the **big winners** in this situation are the insurance companies, who charge large premiums for health insurance, while denying claims they view as too costly. The **big losers** in this situation appear to be patients in need of expensive treatments. The question is, should patients lose the right to receive treatment so managed care organizations can save money?

The Oklahoma City healthcare citizens groups raise this concern in response to a report released today that found over 60% of Americans are now members of managed care organizations. The fear is that as the number of managed care members increases, there will be more and more patients who are denied necessary treatment from their managed care organizations. It is feared that patients will continue to **lose the right to choose** their own doctor as long as managed care continues its current strategy of denying payment to non-member physicians. The lawsuit was filed in an effort to stop managed care organizations from denying patients access to necessary treatments. We will keep you updated as this **battle** unfolds.

Appendix D
Message Pretest

This survey asks some questions about the information in the news story you viewed earlier. Please write the number that corresponds to your opinion of the following statement on the line next to word.

7 = Strongly Agree
6 = Agree
5 = somewhat Agree
4 = neutral
3 = somewhat disagree
2 = disagree
1 = strongly disagree

(Episodic)

_____ The story described specific examples of managed care organizations who denied care to their members.
_____ The story discussed victims of problems with managed care organizations.
_____ The story gave real examples of the problems of managed care.
_____ The story showed how a specific managed care organization is responsible for problems in medical care.
_____ This story included pictures of real people, other than the news reporter.

(Thematic)

_____ This story discussed managed care in general terms, without discussing one specific company or organization.
_____ This story included a news person reporting on an issue, but did not include pictures of other people.
_____ This story focused more on how this problem affects society as a whole
more than it discussed how the problem affects an individual person.
_____ This story did not give any real examples of people who have problems with managed care.

(Strategic)

_____ This story specifically discussed "winners and losers" in managed care organizations.
_____ This story talked about an attack on patients rights by managed care organizations
_____ This story talked about strategies managed care uses to save money.
_____ This story showed how managed care organizations come up with strategies and tactics to deny patients' expensive operations.

Appendix E
Survey Instrument

PART I: The first section of this survey asks some general questions about you. Please answer the following:

1. What is your ethnicity (race)? (Place an X next to the appropriate response category below)

_____Caucasian	_____Hispanic-American
_____African-American	_____Native American
_____Asian-American	_____Other (specify_____)

2. What is your gender? (Place an X next to the appropriate response category below)

_____Female	_____Male

3. How old are you today? (Write your age in the space below)
_____ years old

4. **What is your classification at OU? (Place an X next to the appropriate response)**

_____ **Freshman**	_____ **Junior**	_____ **Other**
_____ **Sophomore**	_____ **Senior**	

5. **Currently, are you:**

_____ **Single/Never married**	_____ **Divorced**
_____ **Married but separated**	_____ **Other**

(please specify below)
_____ **Married**
_____

6. **Do you have any children?**
_____ **I do not have any children**
_____ **I have a child/children who live with me**
_____ **I have a child/children who live with someone other than me**

7. **If you have children, what are their ages?**
_____ **I do not have any children (go on to the next question)**
My oldest child is _____ years old
My second child is _____ years old
My third child is _____ years old
My fourth child is _____ years old
Please list the ages of any additional children on the line below.
_____

8. **I am:**
_____ **not employed outside the home**
_____ **employed part time**
_____ **employed full time**

9. Do you currently have health insurance (check all that apply):
   _____ I do not currently have health insurance.
   _____ I am insured through the student health plan here at OU.
   _____ I am insured through my parents' insurance plan.
   _____ My health insurance is a health maintenance organization, or HMO.
   _____ My health insurance is a Preferred Provider Organization, or PPO.
   _____ My health insurance is a traditional fee for service health plan.

STOP. We will continue with the survey after viewing a short video.

PART II:

Managed care organizations are concerned with the delivery and financing of health care. Based on the news story you just viewed, the first section asks some questions about your opinions of doctors, nurses, managed care providers, hospitals, and insurance companies. **Please carefully read each statement.** Write the number that corresponds to your opinion of the following statements on the line next to each

7 = Strongly Agree
6 = Agree
5 = somewhat Agree
4 = neutral
3 = somewhat disagree
2 = disagree
1 = strongly disagree

_____ Managed care is good for all patients.

_____ Managed care organizations are honest with their patients.

_____ Managed care organizations have integrity.

_____ Managed care organizations use sound moral principles to make decisions about the care of patients.

_____ Patients in managed care organizations are treated fairly.

_____ Managed care organizations care more about patients than about profits.

_____ Being a doctor is very important profession.

_____ Doctors are always honest with their patients.

_____ I have total trust in doctors' advise when I am sick.

_____ Doctors care more about patients than about profits.

_____ Doctors who work for managed care organizations always choose the best treatment options for their patients, regardless of costs.

_____ I have total trust in nurses' advise when I am sick.

_____ Nurses care more about patients than about profits.

_____ Nurses who work for managed care organizations always choose the best treatment options for their patients, regardless of costs.

_____ Nursing is a very important professional.

_____ Nurses are all very honest.

_____ Hospitals work hard to meet the needs of their communities.

PART II CONTINUED: Please carefully read each statement. Write the number that corresponds to your opinion of the following statements on the line next to each sentence.

7 = Strongly Agree
6 = Agree
5 = somewhat Agree
4 = neutral
3 = somewhat disagree
2 = disagree
1 = strongly disagree

_____ Hospital employees are always very honest with patients.

_____ I have total trust in hospital employees advise when I am sick.

_____ Hospitals care more about patients than about profits.

_____ Hospital employees who are part of managed care organizations always choose the best treatment options for their patients, regardless of costs.

_____ Insurance companies work hard to meet the needs of people they insure.

_____ Insurance companies are always very honest with patients.

_____ I have total trust in insurance companies.

_____ Insurance companies care more about patients than about profits.

_____ Insurance companies that are part of managed care organizations always choose the best treatment options for their patients, regardless of costs.

_____ Members of managed care have a duty to seek out information about their health

_____ Representatives of managed care organizations will do almost anything to save money

_____ Managed care organizations try to do what is best for patients.

_____ Managed care organizations almost never keep their word to pay for patients' necessary medical expenses.

_____ In a managed care organization, patients, doctors and insurance companies must be willing to compromise.

Part II Continued:

7 = Strongly Agree
6 = Agree
5 = somewhat Agree
4 = neutral
3 = somewhat disagree
2 = disagree
1 = strongly disagree

_____ Every single patient is important in a managed care organization

_____ Managed care organizations waste the money patients' pay in insurance premiums

_____ In a managed care organization, patients should take an active role in making sure they get the best care possible.

_____ Managed care organizations don't care about what patients think.

_____ Sometimes the financing of health care is so confusing, people like me can't really figure out what's going on.

PART III:
This section asks questions some questions about you. **Please carefully read each statement**. Write the number that corresponds to your opinion of the following statements on the line next to each question.

7 = Strongly Agree
6 = Agree
5 = somewhat Agree
4 = neutral
3 = somewhat disagree
2 = disagree
1 = strongly disagree

_____When I make plans, I am certain I can make them work.

_____One of my problems is that I cannot get down to work when I should.

_____When I set important goals for myself, I rarely achiever them.

_____I give up on things before I complete them.

_____I avoid facing difficulties.

Part III Continued:

7 = Strongly Agree
6 = Agree
5 = somewhat Agree
4 = neutral
3 = somewhat disagree
2 = disagree
1 = strongly disagree

_____If something looks too complicated, I will not even bother to try it.

_____When I have something unpleasant to do, I stick to it until I finish it.

_____When I decide to do something, I go right to work on it.

_____When trying to learn something new, I soon give up if I am not initially successful.

_____When unexpected problems occur, I don't handle them very well.

_____I avoid trying to learn new things when they look too difficult for me.

_____Failure just makes me try harder.

_____I feel insecure about my ability to do things.

_____I am a self-reliant person.

PART IV:

The next section asks some questions about things you might do if you were a member of a managed care organization like the one discussed in the news story you just viewed. Please write the number that corresponds to your opinion of the following statements on the line next to each statement.

7 = Strongly Agree
6 = Agree
5 = somewhat Agree
4 = neutral
3 = somewhat disagree
2 = disagree
1 = strongly disagree

If I belonged to a managed care organization:

_____ I would tell my friends and family that managed care is very good for patients

_____ I would question my doctor about recommendations regarding my health.

_____ I would seek out information about health issues from sources other than my health care provider.

_____ I would question payment procedures of my managed care organization.

_____ I would definitely join a managed care organization if given the opportunity.

_____ I would think twice about taking a job with company who only offered managed care to its employees

PART V: The next section asks for your feelings about the content of the story you just viewed. Please circle the number that corresponds to your opinion of the following statement. Complete the following sentence:

If I were a member of a managed care organization, the news story I just saw would make me feel ...

Sad

none of this feeling 1 2 3 4 5 6 7 a great deal of this feeling

Dreary

none of this feeling 1 2 3 4 5 6 7 a great deal of this feeling

Dismal

none of this feeling 1 2 3 4 5 6 7 a great deal of this feeling

Gloomy

none of this feeling 1 2 3 4 5 6 7 a great deal of this feeling

Happy

none of this feeling 1 2 3 4 5 6 7 a great deal of this feeling

Joyful

none of this feeling 1 2 3 4 5 6 7 a great deal of this feeling

Content

none of this feeling 1 2 3 4 5 6 7 a great deal of this feeling

Cheerful

none of this feeling 1 2 3 4 5 6 7 a great deal of this feeling

Angry

none of this feeling 1 2 3 4 5 6 7 a great deal of this feeling

Mad

none of this feeling 1 2 3 4 5 6 7 a great deal of this feeling

Enraged

none of this feeling 1 2 3 4 5 6 7 a great deal of this feeling

Furious

none of this feeling 1 2 3 4 5 6 7 a great deal of this feeling

Scared

none of this feeling 1 2 3 4 5 6 7 a great deal of this feeling

Fearful

none of this feeling 1 2 3 4 5 6 7 a great deal of this feeling

Frightened

none of this feeling 1 2 3 4 5 6 7 a great deal of this feeling

Panicky

none of this feeling 1 2 3 4 5 6 7 a great deal of this feeling

Terrified

none of this feeling 1 2 3 4 5 6 7 a great deal of this feeling

PART VI:
This section asks some questions about the information in the news story you viewed earlier. Please write the number that corresponds to your opinion of the following statement on the line next to word.

7 = Strongly Agree
6 = Agree
5 = somewhat Agree
4 = neutral
3 = somewhat disagree
2 = disagree
1 = strongly disagree

_____ The story described specific examples of managed care organizations who denied care to their members.

_____ The story discussed victims of problems with managed care organizations

_____ The story gave real examples of the problems of managed care.

_____ The story showed how a specific managed care organization is responsible for problems in medical care.

_____ This story included pictures of real people, other than the news reporter.

_____ This story discussed managed care in general terms, without discussing one specific organization.

_____ This story included a news person reporting on an issue, but did not include pictures of other people.

_____ This story focused more on how this problem affects society more than how it affects an individual person.

_____ This story did not give any real examples of people who have problems with managed care.

_____ This story specifically discussed "winners and losers" in managed care organizations.

_____ This story talked about an attack on patients rights by managed care organizations

_____ This story talked about strategies of managed care to save money.

_____ This story showed how managed care organizations come up with strategies and tactics to deny patients' expensive operations.

Appendix F
Institutional Review Board Informed Consent

Informed Consent Form for Research
University of Oklahoma, Norman, Oklahoma
For
Perceptions of News Stories

This research is being conducted under the auspices of the University of Oklahoma, Norman campus. This document is your consent form for participation in the research project with said conditions listed below.

Principal Investigator: **Melinda Morris Villagran**
Department of Communication

Description: The purpose of this study is to examine perceptions of different types of television news stories. You will be asked to complete a survey after viewing a videotape of a news story from a local news station. There are no foreseeable risks or discomforts expected for participants in relation to this study. At any time, if you feel uncomfortable you can terminate your participation. Participants stand to benefit from a better understanding of how viewers perceive television messages.

Approximate duration of Study: 45 minutes to an hour

Consent: I hereby give my consent to participate in this study. I understand that:

1.I must be at least 18 years of age to participate in this study.

2.My participation is entirely voluntary. Refusal to participate will involve no penalty or loss of benefits to which I am entitled.

3.I may terminate my participation at any time during the duration of the study with penalty.

4. Any information I may give during my participation in this study will be used for research purposes only. Responses will not be shared with anyone not directly involved in this study, except for other researchers who might want to use the data for secondary analysis, for further research in this area.

5. Any information I give during this study will be kept confidential. Only researchers will be able to match my questionnaire with the research design condition in which I participate. The researcher will store data in secure cabinet in a university office. Additionally, the Informed Consent Form will be kept separately from the raw data and destroyed three years after the completion of the research project.

6. I understand, that as a participant, that there are no foreseeable risks involved in participating in this study. If anything in this study upsets me, I understand that there is counseling available at Goddard Health Center here on campus (325-4611).

7. I understand that if I am participating in this experiment to obtain course research participation credit and I decide to withdraw from participation, I might not get credit associated with the experiment. **I must complete the entire questionnaire to receive course research participation credit**

If you have any questions, you can reach the primary investigator Melinda Morris Villagran by phone at 325-0809 or by email at (mmorris@ou.edu); or the faculty sponsor, Dr. Dan O'Hair by phone at (405) 325-3111 or by email at hdohair@@ou.edu); or by contacting the Department of Communication, 101 Burton Hall, University of Oklahoma, Norman, OK, 73019. If you have any questions about the rights of the research participants, please contact the Office of Research Administration at (405) 325-4757.

I hereby agree to participate in the above-described research. I understand that participation is voluntary and that I may withdraw at any time without penalty or loss of benefits.

Signature: _____ Date: _____

Printed Name:_____

Table 1
Principal Components Factor Analysis With Oblique Rotation:
Beliefs about Managed Care Scale

Item	1	2	3	4
Managed care organizations are honest with their patients.	**.82**	.00	.00	.00
Managed care organizations have integrity.	**.90**	.00	.00	.00
Managed care organizations use sound moral principles To make decisions about patients.	**.88**	.00	.00	.00
Patients of managed care organizations are treated fairly.	**.87**	.12	.00	.00
Managed care organizations care more about patients than profits.	**.73**	.00	.12	.14
Doctors are always honest with their patients.	.19	**.56**	-.30	.00
I have total trust in doctors' advise when I am sick.	.00	**.57**	-.30	.00
Doctors care more about patients than about profits.	.00	**.82**	-.10	.00
Nurses are all very honest.	.00	**.70**	-.12	.00
I have total trust in nurses' advise when I am sick.	.00	**.61**	-.29	.00
Nurses care more about patients than about profits.	.00	**.87**	.13	.00
Hospitals work hard to meet the needs of their communities.	.00	.00	**-.84**	.00
Hospital employees are always very honest with patients.	.00	.21	**-.68**	.00
I have total trust in hospital employees' advise when I am sick.	.00	.00	**-.83**	.16
Hospitals care more about patients than about profits.	.00	.11	**-.62**	.25
Hospitals who are part of managed care organizations always choose the best treatment options for their patients, regardless of costs.	.25	.00	**-.58**	.15
Insurance companies work hard to meet the needs of their communities.	.00	.00	-.00	**.77**
Insurance companies are always very honest with patients.	.00	.00	.00	**.89**
I have total trust in insurance companies	.00	.00	.00	**.89**
Insurance companies care more about patients than about profits.	.00	.00	.12	**.90**
Insurance companies are part of managed care organizations always choose the best treatment options for their patients, regardless of costs.	.17	.00	.00	**.73**
Eigenvalues over 1.212	43.4%	13.07%	6.49%	.38%

Total Variance Explained: 67.4%

Table 2
Beliefs about Managed Care Confirmatory Factor Analysis

Item	1	2	3	4	5	**Factor Loading**
Managed care organizations are honest with their patients.	.66	.04	.06	.03	.00	**.81**
Managed care organizations have integrity.	.73**	.73	.01	.01	.00	**.85**
Managed care organizations use sound moral principles to make decisions about patients.	.66**	.75**	.79	.00	.06	**.89**
Patients of managed care organizations are treated fairly.	.67**	.72**	.77**	.74	.02	**.86**
Managed care organizations care more about patients than profits.	.54**	.57**	.66**	.60**	.54	**.67**

Communalities listed on the diagonal, correlations listed in the bottom triangle, errors reported on the top triangle. ** = correlations $p < .01$.

Table 3
Beliefs about Doctors Confirmatory Factor Analysis

Item	1	2	3	4	**Factor Loading**
Doctors are always honest with their patients.	.61	.04	.00	.04	**.78**
I have total trust in doctors' advise when I am sick.	.62**	.63	.04	.04	**.79**
Doctors care more about patients than about profits.	.48**	.57**	.45	.00	**.67**
Doctors who work for managed care organizations always choose the best treatment options for their patients, regardless of costs.	.51**	.43**	.40**	.36	**.60**

Communalities listed on the diagonal, correlations listed in the bottom triangle, errors reported on the top triangle. ** = correlations $p < .01$.

Table 4
Beliefs about Nurses Confirmatory Factor Analysis

Item	1	2	3	4	5	**Factor Loading**
It is very prestigious to be a nurse or health care professional.	.61	.01	.05	.02	.02	**.52**
Nurses are all very honest.	.42**	.63	.04	.03	.01	**.79**
I have total trust in nurses' advise when I am sick.	.51**	.66**	.45	.02	.01	**.88**
Nurses care more about patients than about profits.	.33**	.58**	.58**	.36	.01	**.68**
Nurses who work for managed care organizations always choose the best treatment options for their patients, regardless of costs.	.34**	.56**	.63**	.49**	.37	**.70**

Communalities listed on the diagonal, correlations listed in the bottom triangle, errors reported on the top triangle. ** = correlations $p < .01$.

Table 5
Beliefs about Hospitals Confirmatory Factor Analysis

Item	1	2	3	4	5	**Factor Loading**
Hospitals work hard to meet the needs of their communities.	.50	.06	.00	.01	.06	**.71**
Hospital employees are always very honest with patients.	.65**	.69	.04	.03	.00	**.83**
I have total trust in hospital employees' advise when I am sick.	.60**	.66**	.71	.01	.04	**.84**
Hospitals care more about patients than about profits.	.55**	.63**	.67**	.62	.02	**.79**
Hospitals who are part of managed care organizations always choose the best treatment options for their patients, regardless of costs.	.45**	.60**	.64**	.59**	.52	**.72**

Communalities listed on the diagonal, correlations listed in the bottom triangle, errors reported on the top triangle. ** = correlations $p < .01$.

Table 6
Beliefs about Insurance Companies Confirmatory Factor Analysis

Item	1	2	3	4	5	**Factor Loading**
Insurance companies work hard to meet the needs of their communities.	.64	.05	.01	.04	.03	**.80**
Insurance companies are always very honest with patients.	.77**	.82	.02	.02	.03	**.90**
I have total trust in insurance companies' advise when I am sick.	.75**	.85**	.85	.01	.01	**.92**
Insurance companies care more about patients than about profits.	.62**	.72**	.74**	.68	.09	**.82**
Insurance companies are part of managed care organizations always choose the best treatment options for their patients, regardless of costs.	.58**	.65**	.69**	.59**	.58	**.76**

Communalities listed on the diagonal, correlations listed in the bottom triangle, errors reported on the top triangle. ** = correlations $p < .01$.

Table 7
Principal Components Factor Analysis With Oblique Rotation: Emotion Scale

If I were a member of a managed care organization, the news story I just viewed would make me feel ...	**1 Fear**	**2 Happiness**	**3 Sadness**	**4 Anger**
Scared	**.95**	-.11	.00	.00
Fearful	**.92**	.00	.00	.00
Frightened	**.89**	.00	.00	.00
Panicky	**.85**	.00	.00	.14
Terrified	**.88**	.00	.00	.00
Happy	.00	**.93**	.00	.00
Joyful	.00	**.91**	.00	.00
Content	.00	**.87**	.00	.00
Cheerful	.00	**.95**	.00	.00
Sad	.00	.00	**.88**	.00
Dreary	.00	.00	**.97**	.00
Dismal	.00	.00	**.92**	.00
Gloomy	.00	.21	**.85**	.00
Angry	-.11	.00	.00	**.93**
Mad	.00	.00	.00	**.90**
Enraged	.00	.00	.00	**.91**
Furious	.15	.00	.00	**.84**
Eigenvalues over 1.212	51.02%	18.97%	8.38%	7.13%

Total Variance Explained: 85.5%

Table 8
Emotions Scale Confirmatory Factor Analysis
Happiness Subscale

"If I were a Member of a managed care organization, the news story I just saw would make me feel ..."

Item	1	2	3	4	**Factor Loading**
Happy	.85	.03	.00	.02	**.92**
Joyful	.86**	.82	.03	.01	**.90**
Content	.75**	.70**	.65	.03	**.81**
Cheerful	.84**	.86**	.79**	.89	**.95**

Communalities listed on the diagonal, correlations listed in the bottom triangle, errors reported on the top triangle. ** = correlations $p < .01$.

Table 9
Emotions Scale Confirmatory Factor Analysis
Sadness Subscale

"If I were a Member of a managed care organization, the news story I just saw would make me feel ..."

Item	1	2	3	4	**Factor Loading**
Sad	.68	.10	.02	.05	**.82**
Dreary	.78**	.86	.03	.05	**.92**
Dismal	.71**	.83**	.79	.03	**.89**
Gloomy	.75**	.81**	.82**	.81	**.90**

Communalities listed on the diagonal, correlations listed in the bottom triangle, errors reported on the top triangle. ** = correlations $p < .01$.

Table 10
Emotions Scale Confirmatory Factor Analysis
Anger Subscale

"If I were a Member of a managed care organization, the news story I just saw would make me feel ..."

Item	1	2	3	4	**Factor Loading**
Angry	.68	.07	.04	.05	**.82**
Mad	.87**	.93	.03	.03	**.97**
Enraged	.73**	.86**	.87	.07	**.93**
Furious	.70**	.83**	.91**	.80	**.90**

Communalities listed on the diagonal, correlations listed in the bottom triangle, errors reported on the top triangle. ** = correlations $p < .01$.

Table 11
Emotions Scale Confirmatory Factor Analysis
Fear Subscale

"If I were a Member of a managed care organization, the news story I just saw would make me feel ..."

Item	1	2	3	4	5	**Factor Loading**
Scared	.80	.10	.02	.05	.06	**.89**
Fearful	.93**	.87	.03	.05	.06	**.93**
Frightened	.87**	.92**	.92	.03	.02	**.96**
Panicky	.71**	.74**	.79**	.73	.14	**.85**
Terrified	.71**	.74**	.81**	.87**	.74	**.86**

Communalities listed on the diagonal, correlations listed in the bottom triangle, errors reported on the top triangle. ** = correlations $p < .01$.

Table 12
Correlations Among the Retained Behavior Subscale Items

If I belonged to a managed care organization...

Item	1	2	3
I would question my doctor about recommendations regarding my health.	1.0		
I would seek out information about health issues from sources other than my health care provider.	.71**	1.0	
I would question payment procedures of my managed care organization.	.54**	.68**	1.0

** = correlations $p < .01$.

Table 13
Principal Components Factor Analysis With Oblique Rotation:
Manipulation Check Framing Scale

Item	Episodic Frame	Thematic Frame	Strategic Frame
The story described specific examples of managed care organizations who denied care to their members.	**.78**	-.17	.00
The story discussed victims of problems with managed care organizations.	**.79**	-.11	.00
The story gave concrete examples of the problems with managed care organizations.	**.79**	-.18	.17
The story showed how a specific managed care organization is responsible for problems in medical care.	**.76**	-.30	.00
The story discussed managed care in general terms, without discussing a specific company or organization.	-.10	**.76**	.00
The story included a news person reporting on an issue, but did not include pictures or other people.	-.24	**.84**	.00
The story focused on how this problem affects society as a whole more than it discussed how the problem affects an individual person.	-.18	**.77**	.0
This story did not give any concrete examples of people who have problems with managed care.	-.32	**.73**	-.18
The story specifically discussed winners and losers in managed car organizations.	.00	.15	**.65**
This story talked about an attack on patients' rights by managed organizations.	.00	.00	**.73**
This story talked about strategies of managed care to save money.	.00	-.27	**.75**
This story showed how managed care organizations come up with strategies and tactic to deny patients' expensive operations.	.00	-.30	**.79**

Eigenvalues over 1.188
Total Variance Explained: 63.6%

Table 14
Manipulation Check Confirmatory Factor Analysis
Episodic Frame Scale

Item	1	2	3	4	**Factor Loading**
The story described specific examples of managed care organizations who denied care to their members.	.75	.02	.05	.02	**.86**
The story discussed victims of problems with managed care organizations.	.70**	.71	.03	.05	**.84**
The story gave concrete examples of the problems with managed care organizations.	.46**	.43**	.42	.03	**.67**
The story showed how a specific managed care organization is responsible for problems in medical care.	.46**	.48**	.21**	.46	**.71**

Communalities listed on the diagonal, correlations listed in the bottom triangle, errors reported on the top triangle. ** = correlations $p < .01$.

Table 15
Manipulation Check Confirmatory Factor Analysis
Thematic Frame Scale

Item	1	2	3	4	**Factor Loading**
The story discussed managed care in general terms, without discussing a specific company or organization.	.60	.02	.04	.00	**.91**
The story included a news person reporting on an issue, but did not include pictures or other people.	.44**	.97	.03	.02	**.95**
The story focused on how this problem affects society as a whole more than it discussed how the problem affects an individual person.	.30**	.51**	.79	.00	**.84**
This story did not give any concrete examples of people who have problems with managed care.	.39**	.79**	.47**	.70	**.87**

Communalities listed on the diagonal, correlations listed in the bottom triangle, errors reported on the top triangle. ** = correlations $p < .01$.

Table 16
Manipulation Check Confirmatory Factor Analysis
Strategic Frame Scale

Item	1	2	3	4	**Factor Loading**
The story specifically discussed winners and losers in managed car organizations.	.68	.04	.02	.02	**.83**
This story talked about an attack on patients' rights by managed organizations.	.29**	.63	.03	.01	**.58**
This story talked about strategies of managed care to save money.	.29**	.39**	.52	.05	**.72**
This story showed how managed care organizations come up with strategies and tactic to deny patients' expensive operations.	.32**	.45**	.63**	.66	**.81**

Communalities listed on the diagonal, correlations listed in the bottom triangle, errors reported on the top triangle. ** = correlations $p < .01$.

Table 17
Means and Standard Deviation for Variables

Frame	**Episodic**		**Thematic**		**Strategic**		**Control**	
Efficacy	Low	High	Low	High	Low	High	Low	High
Beliefs	4.35 (.96)	4.12 (.97)	4.01 (.97)	4.31 (.88)	3.27 (.96)	4.05 (.89)	4.19 (.65)	4.47 (.71)
Emotions	4.98 (.94)	5.23 (1.02)	3.38 (1.27)	3.60 (1.06)	4.69 (1.21)	4.55 (1.25)	3.21 (.97)	3.57 (1.18)
Behavior	2.52 (1.81)	3.70 (1.88)	2.77 (1.93)	3.44 (1.47)	2.72 (1.66)	4.44 (1.50)	2.76 (1.51)	3.67 (1.63)
Insurance	3.23 (1.06)	3.43 (1.28)	2.60 (1.28)	3.05 (1.32)	3.35 (.18)	3.47 (.41)	3.68 (1.08)	3.72 (1.20)
Hospitals	2.97 (.93)	4.32 (1.16)	2.65 (1.16)	4.67 (.99)	4.02 (1.27)	4.46 (1.15)	4.43 (.63)	4.81 (.90)
Nurses	4.46 (.85)	4.76 (1.21)	3.98 (.99)	4.55 (.89)	4.30 (.89)	4.76 (.86)	4.50 (1.02)	4.68 (.82)
Doctors	4.33 (.97)	4.84 (1.12)	3.96 (1.10)	4.78 (.91)	4.41 (.99)	4.74 (.90)	4.41 (1.21)	4.86 (.75)
Managed Care	3.62 (1.09)	3.68 (1.03)	3.12 (1.28)	3.82 (1.23)	2.52 (1.16)	2.73 (1.11)	4.32 (.43)	4.07 (1.03)
Sadness	4.64 (1.44)	5.14 (1.39)	4.24 (1.33)	4.21 (1.42)	4.13 (1.81)	4.39 (1.62)	3.25 (1.50)	3.44 (1.41)
Happiness	1.58 (.89)	1.68 (.90)	1.82 (1.37)	1.73 (.97)	2.16 (1.16)	1.98 (.87)	3.60 (1.51)	3.60 (1.02)
Anger	4.73 (1.7)	4.34 (1.78)	4.88 (1.74)	4.67 (1.56)	4.8 (1.64)	5.12 (1.26)	3.42 (1.48)	3.23 (1.45)
Fear	4.25 (1.56)	3.50 (1.89)	3.89 (1.66)	3.94 (1.55)	4.18 (1.74)	3.66 (1.85)	2.98 (1.38)	2.73 (1.75)

Table 18
Correlations Among Variables
Included in the Path Model

Variable	1	2	3	4	5
Message Frame Type	1.0				
Self-Efficacy Level	.04	1.0			
Beliefs About Managed Care	.05	.31**	1.0		
Emotions	-.22**	.01	-.17*	1.0	
Behavior	-.03	-.09	.07	.10	1.0

** Correlation is significant at the .01 level
* Correlation is significant at the .05 level

Figure 1: Proposed Path Model Diagram

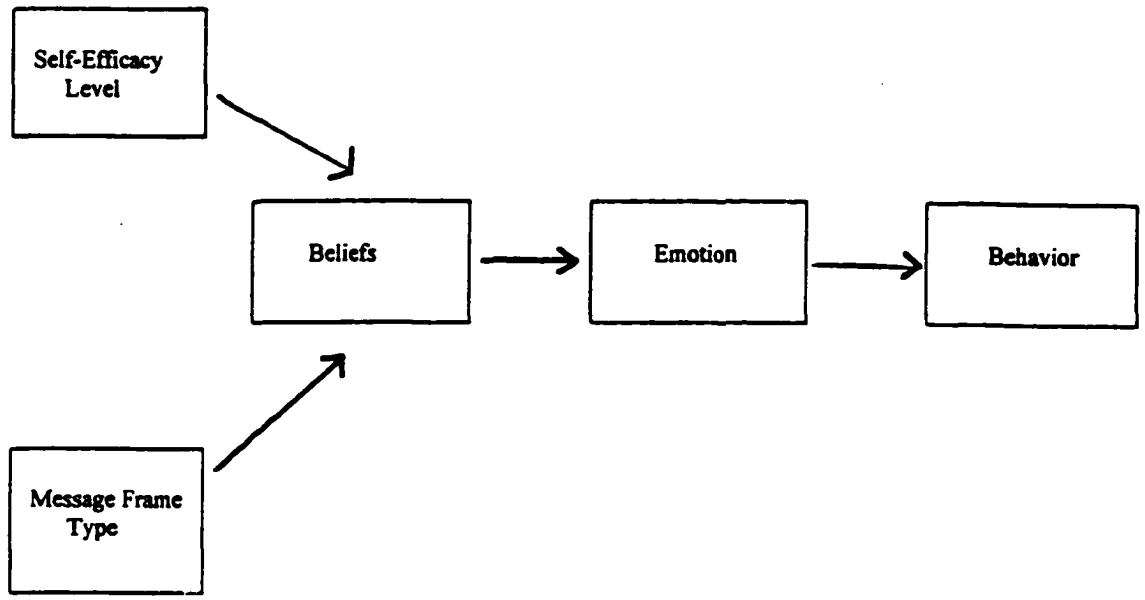
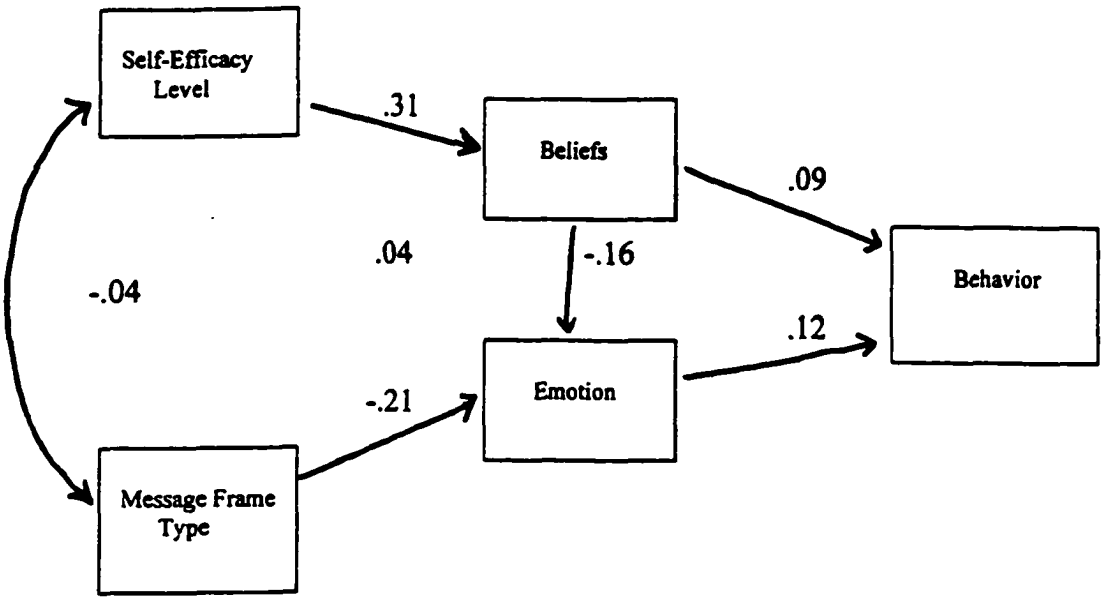


Figure 2: Path Model Diagram



*: $\chi_2 = 1.96$, df (3), $p > .05$

** For purposes of simplicity, variables measuring beliefs, emotions, and behavior are collapsed in the path diagram above. All scale variables were accounted for in this model.