AN ABSTRACT OF THE THESIS OF

Michael F.James for the Master of Science

in Psychology presented on July 16, 2001

Title: Investigation of Attitudes Toward People with Mental Illness

Abstract approved: Kenneth A. Weaver

Since the passage of the federal Community Mental Health Centers Act in 1963 changes in treatment and care for individuals with mental illnesses have occurred. Local communities now provide assistance and services for people with mental illness. Understanding attitudes held by these communities is important. This study tested three hypotheses: Perceptions of people labeled mentally ill would differ depending on whether the individual reports personal views or the views perceived to be held by others; gender of participants would not influence attitudes reported toward people with a mental illness; and gender would not influence attitudes when an individual reports personal views or the views perceived to be held by others. The attitudes of 104 college students enrolled in introductory psychology classes were measured using the Community Attitudes toward Mental Illness scale (CAMI). The CAMI's four subscales, measure authoritarianism, benevolence, social restrictiveness, and community mental health ideology. A 2 x 2 mixed factor MANOVA and four 2 x 2 ANOVAs were calculated to examine the effect and interaction of gender and viewpoint reported on the four attitudes measured. Gender and Viewpoint main effects were significant as were a number of interactions. Women reported more accepting attitudes and stronger attitudes than men did. Participants reported personal attitudes differed significantly from the perceived attitudes of others.

Women reported their personal view as being more different from others than men perceived their personal attitudes to be.

The findings of this study indicate a need for continued investigation of attitudes. A need to incorporate into mental health policy actions that help continue the trend of demystifying mental illness. The findings also indicate a need to continue to acknowledge there are differences in attitudes between men and women and that this may impact how both professionals and the general population approach individuals with a mental illness.

INVESTIGATION OF ATTITUDES TOWARD PEOPLE WITH MENTAL ILLNESS

Thesis

Presented to

The Department of Psychology and Special Education

EMPORIA STATE UNIVERSITY

In Partial Fulfillment

of the Requirements for the Degree

Master of Science

By

Michael F. James

Kenneth A. Weaver

Approved for the Department
of Psychology and Special Education

Timothy M. Lowrey

Approved for the Graduate Council

ACKNOWLEDGEMENTS

I would like to express my thanks to Dr. Ken Weaver, Dr. Kurt Baker, Dr. Cooper Holmes and Dr. Edmund Hanson, for their time, guidance and most abundant patience and understanding. I also wish to thank Nahree Doh , Brandy Smith and Ginger Graumann for their time, assistance, encouragement, and friendship. Many others are due thanks in the long in coming completion of this project. Thank you to all my friends and family that supported me through graduate school.

TABLE OF CONTENTS

LIST OF TABLES

Tables

CHAPTER 1

INTRODUCTION

As the 21st century begins, the structure of mental health services continues to change. In 1963 the Federal Community Mental Health Center Act was passed, providing mental health care to the community through local centers instead of large hospitals. This marked a major change in "deinstitutionalization" but has raised many questions for those caring for individuals with mental illness. Method of provision of care, personnel qualified to provide care, and community reaction to the shift away from institutions were all topics of concern. Mental health has been grappling with major shifts in methods of care for decades with limited success due to poor understanding of the environment in which the care is being delivered (i.e., the general community). Community-based care requires an adequate understanding of community attitudes toward mental illness. This study served to broaden this knowledge base by investigating attitudes toward mental illness.

This project examined the attitudes toward people with mental illness by individuals without extensive training in psychology or a related field. Historically, those with mental illnesses have been isolated from the general population with contact only from those trained in psychology or psychiatry and other people with mental illness. The current trend, however, is to move from institutional method of care, where isolation from society is a part of treatment, to a community-based plan of care, where individuals with mental illness are incorporated into the general population with support services.

Those previously providing care in the institutional setting are now faced with considering the client in a community. Understanding this larger more diverse

environment is essential to providing quality care. Families often abandon members with mental illness, thus the care for individuals with mental illness often becomes the responsibility of the greater community of health care providers, mental health workers, and social workers. By understanding the general population's attitudes toward mental illness, clinicians can help prepare those with illnesses to deal with the communities' reactions to their illness, while disproving myths and misconceptions.

Many components must be examined to understand community perceptions of people with mental illness. Major areas of consideration include the portrayal of individuals with mental illness in the popular media, cultural and ethnic beliefs, education levels, age and experience or contact with individuals with mental illness. Examining reactions to the label of mental illness or to behavioral patterns of mental illness can elicit an understanding of how people perceive mental illness and formulate their attitudes toward people with a mental illness in the population. Investigating attitudes helps identify the stereotypes, misconceptions, and beliefs among those without formal training about mental illnesses. Investigating attitudes toward individuals with mental illness in society is important for a number of reasons. Professionals who become aware of community attitudes can improve the method by which people with mental illnesses are integrated into and cared for within a community. Another benefit is refocusing attention from understanding mental illness to client accommodation to mental illness. Understanding the views of the rest of society toward mental illness informs professionals with the knowledge needed to help clients deal with those perceptions and attitudes. Information regarding societal attitudes toward mental illness can help professionals assist their clients' return to the community. Increased knowledge of the

community helps professionals identify skills necessary for clients to integrate into the community.

Literature Review

Factors influencing perceptions of mental illness include public attitudes concerning mental illness (Aurbry, Tefft, & Carrie, 1995; Brockington, Hall, Levings, & Murphy, 1993; Hall, Brockington, Levings & Murphy, 1993; Wolff, Pathare, Craig, & Leff, 1996a), the general community knowledge of mental illness (Wolff, Pathare, Craig, & Leff, 1996b), labeling individuals as mentally ill (Socall & Holtgraves, 1992), stigmas associated with mental illness (Deforges et al., 1991; Flynn, 1987; Skinner, Berry, Griffith & Byers, 1995), and methods used to measure the influence of labels and the stigma placed on individuals with mental illness (Farina, Fisher, Boudreau, & Belt, 1996). Additional variables include age (Roy & Storandt, 1989), education, and cultural, ethnic and gender influences (Malla & Shaw, 1987; Mangum & Mitchell, 1973; Purvis, Brandt, Rouse, Vera, & Range, 1988; Whaley, 1997).

The current body of research is expansive but tends to focus on examining attitudes among either professionals in psychology or related fields or more advanced students of psychology (Ojanen, 1992). Much of the research conducted over the last 10 years was in Europe or Australia (e.g., Ojanen, 1992; Reda, 1996; Shokoohi-Yekta & Retish, 1991; Wolff et al., 1996a; Wolff et al., 1996b). The existing research also focuses on mental illness in terms of those illnesses that are severe and persistent and require long term types of care. A need for further understanding of attitudes and perception of individuals with mental illness in the United States exists. The continued influence of the

Federal Community Mental Health Act such as the closing of major hospitals like Topeka (KS) State Hospital warrants ongoing investigation of community attitudes.

General Attitudes and Knowledge of Mental Illness

Those with mental illness are generally viewed in negative terms. As with most "different" groups (e.g., individuals with behavior problems, individuals with physical disabilities, etc.), prejudices, misperceptions, and stigma influence how people view and treat those with mental illness.

When asked why they had negative attitudes toward people with mental illness being placed in their communities, homeowners responded with a fear of violence, bad previous experiences with group homes, and the effect on property values (Arens, 1993). This "Not in my backyard" attitude is found both in Europe and in the United States (Arens, 1993; Brockington et al., 1993; Wolff et al., 1996). A fear of the unknown and myths about the behavior of individuals with mental illness are at the root of the negative attitudes (Arens, 1993). Although individuals with mental illness do have less predictable behaviors, little research supports a dramatic difference in levels of violence among individuals with most mental illnesses and the general population (Arens, 1993).

The media's portrayal of mental illness is typically one of aggressive and dangerous behaviors (Flynn, 1987). As with any group, individuals with mental illnesses sometimes behave aggressively and violently. Factors such as a history of violent behavior, substance abuse, and noncompliance with medication are better predictors of violent behaviors than a label of mental illness (Torrey, 1994). Unfortunately, mental illness is often credited for the behavior. A few common myths concerning individuals with mental illness are that they are unpredictable and violent, slow or unintelligent, and

cannot recover from a mental illness. According to Flynn (1982), 1 in 11 prime time television programs showed mentally ill characters as being aggressive, dangerous, and unpredictable. Flynn also reported that "in 1980 70% of mentally ill characters on television were violent compared to 45% of normal characters" (p. 56). Although the American Psychological Association (APA) and the National Institute of Mental Health (NIMH) are working to change this trend, individuals with mental illness are still frequently stereotyped as aggressive characters. A general lack of knowledge concerning the nature and frequency of mental illnesses perpetuates the negative perceptions of those with mental illness (Wolff et al., 1996b) and makes it difficult for non-professionals to recognize misrepresentations.

Although many people learn about mental illness through television and movies, printed literature also influences attitudes. Wahl and Kaye (1992) reported an increase in articles and references to mental illness between 1965 and 1988. These articles more accurately present information about mental illnesses. Wahl and Kaye's study illustrates that many changes advocated by organizations like APA and NIMH are being implemented. Specific improvements seen in public education include an increase in articles addressing mental illness and the use of more accurate descriptions of specific disorders, and how they affect people. The media's role is important to consider because it influences the formation and maintenance of biases, labels, and stigmas.

Labeling Theory and Stigma

Labeling theory proposes that individuals labeled as mentally ill will experience prejudice and stigmatization. For example, someone labeled mentally ill may be denied a job or housing. The stigmatization experienced by those labeled as mentally ill often

includes perceptions such as violent or inappropriate behaviors, lack of intelligence or ability to do for themselves. Aubry et al. (1995) state that individuals experiencing prejudice and stigmatization because they were labeled mentally ill often find this stigmatization occurs regardless of their behaviors. Socall and Holtgraves (1992) reported a conflict in the research concerning the influence of labels on attitudes toward mental illness. They cite a number of studies that report behavior, rather than the label, has more influence on the attitude (e.g., Farina, Felner, & Boudreau, 1973). They point out another body of research that illustrates the opposite, behavior has little to do with attitude; the label influences perceptions (e.g., Link, Cullen, Frank, & Wozniak, 1987, in Socall & Holtgraves, 1992). This discrepancy in the literature prevents concluding how much the label influences ideas and attitudes toward mental illness.

A concern when assessing attitudes or perceptions from surveys or interviews is the danger of a social desirability response set that presents people as agreeing with what they perceive to be acceptable. The question becomes whether the reported attitudes coincide with behavior toward people with mental illness. The method employed in the current study was to ask individuals to respond to the same questions twice, once as they would respond and a second time, as they believed other individuals would respond. Based upon Aubry et al. (1995) and Socall and Holtgraves (1992), a difference between reported personal attitudes and the view of others indicate a portion of subtle stigma that individuals with mental illness experience and hint as to how strong social desirability influences personal responses.

Methods and Instrumentation Studying Attitudes

The most commonly used method to measure attitudes is administering instruments such as the Community Attitudes Toward the Mentally Ill (Taylor & Dear, 1981), the Attitude toward Disabled Persons Scale, used by Lyons and Hayes (1993), the Community Acceptance Scale (Purvis et al., 1988), and the Opinion about Mental Illness Scale (Cohen & Struening, 1962). Instruments such as these ask questions about opinions or attitudes for which respondents rate their response on Likert type scales. The advantages of tools such as these are ease of administration and amount of data. Unlike other methods of investigating attitudes, questionnaires do not require special training to administer.

Another method is to present participants with vignettes and then question them concerning behavior and attitudes toward the person described in the vignette. Two less frequently used methods are interviews and Q-sorts. Interview methods range in structure and type. There are four basic types of interview: structured, semi-structured, informal and retrospective (Fraenkel & Wallen, 1996). The structured type consists of prewritten or prescribed questions asked in the same order. Semi-structured interviews have prescribed questions, but the interviewer decides which questions come next in reaction to interviewee's responses. An informal style of interview is comparable to a casual conversation. Retrospective is an interview that asks the interviewee to report and recall past information. There are numerous advantages to interview methods. Confusing questions can be clarified, response rates to questions improved, and more in-depth knowledge obtained. With interviews also come disadvantages including a potential increase in a social desirability effect, the interviewees may be more self-conscious of their answers, and more time and training is needed to conduct reliable interviews

(Fraenkel & Wallen 1996). Q-sorts like interviews are ways to potentially gain more information than a straightforward questionnaire. A Q-sort typically consists of a number of statements on cards that an individual sorts into an order (e.g., importance, frequency, etc.). For example, to study perceptions of mental illness a researcher might have participants sort statements about how they would treat someone with mental illness or about people with mental illness that they believe to be true.

Farina et al. (1996) found that a written presentation versus visual and auditory presentation of a mentally ill individual influenced the attitudes expressed. A written description did not elicit a different response than a video or confederate playing the role of a mentally ill individual however when considering social status, people were viewed more negatively with increase in concreteness (i.e., more detail provided) of presentation. Given the variety and age (20 years or more) of many of the instruments, generalizing results across studies is difficult because the techniques used seem to measure different aspects of the same attitudes or definitions of the attitudes measured vary across studies. For example, in one study benevolence may be used and defined one way than in another the researchers may alter the definition of an attitude yet still calling it benevolence. Further study of attitude assessment techniques is needed. The variety of methods assessing attitudes provides both positives and negatives when investigating attitudes. The strength of varied methods is the potential to assess different aspects of the same phenomenon. Unfortunately, this strength can also be a weakness because it decreases the generalizability of findings, as each method may not be assessing the same phenomenon.

Extraneous Variables

Three attitudes commonly measured include social distance/authoritarianism, reflecting a view of those with mental illness as inferior and needing forceful handling; social restrictiveness, reflecting a view of the mentally ill as threats that need to be separated from society; and benevolence which is more humanistic, providing a sympathetic view of those with mental illness (Pomberg, 1998; Shokoohi-Yekta & Retish, 1991). Gender, age, education level, cultural background, and amount and type of exposure to mental illness influence social attitudes toward individuals with a mental illness (Hall et al., 1993; Malla & Shaw, 1987; Pomberg, 1998; Shokoohi-Yekta & Retish, 1991; Urdaneta, Saldana, & Winkler, 1995; Whaley, 1997). Culture and age have the most consistent influence. Those from minority cultures tend to view mental illness more negatively than those from the majority culture. Over time gender seems to have lost its influence on attitudes in being that recent studies have not found the same effect as earlier studies (Pomberg, 1998).

Given this apparent change in attitudes for men and women, it is important to replicate results such as those found by Pomberg to determine whether the change is reliable or unique to the specific sample studied. Pomberg's (1998) results were consistent with previous research such as attitudes becoming more positive with increased education. The effects of education and general knowledge about mental illness are also seen when one includes culture or ethnic background as factors. Middle class Whites, who are typically more knowledgeable about mental illness than minorities, tend to have more tolerant and benevolent views of mental illness. Although there is some variation across cultures, there is a less positive perception of mental illness among

peoples from non-White cultures (Shokoohi-Yekta & Retish, 1991; Urdaneta et al., 1995; Whaley, 1997). Currently, how culture influences attitudes is unclear. Most studies have not been able to factor out variables like social economic status, which Skinner et al. (1995) found to be related to more negative attitudes toward stigmatized groups in general. Desforges et al. (1991) and Drolen (1993) reported that simply being in the presence of or reading a description about a person with mental illness or generally stigmatized group (e.g., ex-convicts, ex-drug addicts, etc.) often resulted in attitudes that were more negative. They found the amount of time spent being exposed to a stigmatized group had little affect on attitude, but the type of interaction did have an affect. The more peer-like the stigmatized and non-stigmatized groups were, the more positive the attitude. Desforges and colleagues found that giving tasks requiring active cooperation between differing groups facilitated positive change in attitudes toward the stigmatized group.

Hypotheses

For the purpose of this study, three hypotheses were tested:

1. Perceptions of people labeled mentally ill would differ depending on whether the individual reports personal views or the views perceived to be held by others.

2. Gender of participants would not influence attitudes reported toward people with a mental illness.

3. Gender would not influence attitudes when an individual reports views perceived to be held by others.

CHAPTER 2

METHOD

Participants

The sample consisted of 104 students attending a small midwestern state university drawn from students enrolled in introductory psychology courses. All of the participants received course credit for their participation. The only restriction placed on the volunteers was that they did not have more than an introductory level of education in psychology or a related field. Of the 104 participants, 48 were men, 56 were women, and the mean age was 20.46 years (SD = 3.29).

Experimental Design

The study investigated attitudes toward individuals with mental illnesses. The independent variables were gender and reporting perspective. Measures of attitude obtained from the Community Attitudes Toward Mental Illness Scale were the dependent variables.

The variable of exposure to mental illness is extremely difficult to control through sampling protocols. To obtain a rough picture of how much experience the participants had with mental illness, they were asked to report if they had been in therapy themselves or had a close family member or friend that has a mental illness. The restricted access to a more varied population limits control over variables such as cultural and religious background. Because the accessible population tend to be similar on these background variables, it should be possible to generalize to the target population of midwestern university students.

Instrumentation

The Community Attitudes Toward the Mentally Ill (CAMI) Scale was administered to collect the desired data. In 1981, Taylor and Dear constructed the CAMI by modifying the Opinions about Mental Illness (OMI) Scale that Cohen and Stuening designed for health professionals (1962). When Taylor and Dear modified the OMI, they also used some items from the Community Mental Health ideology (CHMI) Scale that Baker and Schulberg constructed in 1967. The CAMI was developed to provide an instrument that would measure and assess public attitudes toward individuals with mental illness. Taylor and Dear's (1981) major goal was to "construct an instrument able to discriminate between those individuals who accept and those who reject the mentally ill in the community" (p. 227). Taylor and Dear used three conceptual categories from the OMI and revised the CMHI scale to apply to the public instead of health professionals.

The CAMI is a 40-item questionnaire divided into four 10-item scales: authoritarianism, benevolence, social restrictiveness, and the CMHI. Each scale contains both negative and positive statements about mental illness. Responses on each item are rated on a 5-point Likert type scale (i.e., strongly agree to strongly disagree). The scores are then summed to obtain a score for each scale. The higher the score on each scale, the more positive the attitude. Authoritarianism, the view that people with mental illnesses need to be hospitalized and that differentiating individuals with mental illness from normal people is easy, was assessed with responses to statements like "The best way to handle the mentally ill is to keep them behind locked doors." Benevolence, the perspective that views society as responsible for providing care for individuals with mental illness and one's willingness to be personally involved was tested with statements

such as "The mentally ill have for too long been the subject of ridicule." Social Restrictiveness, how dangerous people with mental illness are perceived to be and how much social distance from individuals suffering from a mental illness is wanted, is represented by items such as "The mentally ill should be isolated from the rest of the community." The final scale, Community Mental Health Ideology taps into views of how people with mental illness are to fit into communities and neighborhoods. A sample of this scale is "Local residents have good reason to resist the location of mental health services in their neighborhood," (Taylor & Dear, 1981).

Taylor and Dear analyzed the reliability and validity of the CAMI in a pilot study as well as a final study with a sample size of 1,090. Factor analysis verified the construct validity of the four scales in both the pilot study and the final study. The correlation coefficients, in the final study, between the four scales ranged from -.63 to -.77. These coefficients for the scales were slightly higher, suggesting some overlap between scales but comparable to those found on the corresponding scales of the OMI in previous research, demonstrating the questions separate out different aspects of attitudes. Taylor and Dear found the reliability of all four scales between the pilot study and final study to be acceptable, ranging from .68 to .88. The weakest reliability (.68) was found on the Authoritarianism scale, but it was judged as acceptable.

Procedure

At the beginning of each session, the researcher, a 26-year-old White man, briefly explained the procedure. The participants were asked to read and sign the informed consent form (Appendix A). This consent form briefly described the study and informed the participants that they could withdraw their participation at anytime. After the

participants read and signed the consent form, they were given a version of the Community Attitudes Toward the Mentally Ill (CAMI) scale. The instructions requested responses using one's personal opinion and a second set of responses based on how he/she thinks the majority of other people would respond to the questions (Appendix B). After the participants completed the CAMI, they were asked to fill out a short demographic sheet (Appendix C) attached to the questionnaire. The informed consent forms were kept separate from the data to maintain confidentiality of the participants. The task took about 20 minutes after the participants completed the questionnaire and demographic sheet, they were thanked and dismissed.

CHAPTER 3

RESULTS

In this study, a 2 (Gender: men or women) x 2 (Viewpoint: personal and other) mixed-factor multivariate analysis of variance (MANOVA) procedure was done on the four subscales of the Community Attitudes toward Mental Illness (CAMI) scale. Gender (between subjects) and Viewpoint (within subjects) were the independent variables and the four subscales of the CAMI, which were authoritarianism, benevolence, social restrictiveness and community mental health ideology, were the dependent variables. The means and standard deviations for the four scales are presented in Table 1.

The Wilks' Lambda MANOVA test showed a statistically significant main effect, $F(8, 95) = 2.61$, $p < .05$. Each subscale dependent variable was then separately analyzed using a 2 x 2 mixed-factor ANOVA. Tukey's Honestly Significant Difference test was used to understand all significant interactions with an alpha at the .05 level. Pearson Correlations were calculated for the subscales. Table 2 presents the correlations found between scales for both reporting perspectives.

Authoritarianism

The Gender and Viewpoint main effects were significant. Also the Gender x Viewpoint interaction were statistically significant, $F(1, 102) = 54.95$, $p < .001$, and $F(1, 102) = 6.20$, $p < .05$, respectively (see Table 3). Women and men participants rated themselves as more authoritarianism than their rating of others authoritarianism. For the interaction women reported stronger levels of authoritarianism both personally and on there perceived view of others than men rated themselves and others, but both men and women rated others authoritarianism the same.

Table 1

Men's and Women's Means and Standard Deviations for Authoritarianism, Benevolence, Social Restrictiveness, and Community Mental Health Ideology (CMHI) Subscale Scores

	Men		Women		Total	
Group	M	SD	M	SD	M	SD
Authoritarianism Me	33.83	4.15	35.89	3.85	34.94	4.10
Authoritarianism Other	31.18	4.12	30.57	3.94	30.08	5.40
Total	32.51	3.31	33.23	4.33	32.89	3.89
Benevolence Me	33.85	5.61	37.60	3.94	35.87	5.12
Benevolence Other	30.68	4.55	31.08	6.61	30.03	5.86
Total	32.27	3.76	34.61	4.41	33.38	4.23
Social Restrictiveness Me	33.47	5.83	36.98	3.97	35.36	5.20
Social Restrictiveness Other	29.79	4.92	30.25	6.61	30.03	5.86
Total	31.63	4.55	33.61	4.16	32.70	4.43
CMHI Me	30.97	5.94	34.07	6.20	32.64	6.25
CHMI Other	27.97	4.86	28.03	6.92	27.98	6.03
Total	29.44	4.47	31.05	5.60	30.31	5.15

Table 2

Correlations Among Community Attitudes Toward Mental Illness Subscales

Subscales	1	2	3	4	5	6	7	8
1. Authoritarian Other		.33**	.73**	.07	.71**	-.02	.73**	.09
2. Authoritarian Me			.06	.45**	.09	.49**	.16	.50**
3. Benevolence Other				.21*	.79**	-.02	.71**	.03
4. Benevolence Me					.14	.62**	.14	.59**
5. Social Restrictiveness Other						.28**	.74**	.13
6. Social Restrictiveness Me							.14	.67**
7. CMHI[1] Other								.41**
8. CMHI[1] Me								

CMHI[1] Community Mental Health Ideology
* $p < .05$.
** $p < .01$

Table 3

Gender by Viewpoint Analysis of Variance for Authoritarian Subscale Sources

Source	df	SS	MS	F
Gender	1	26.93	26.93	.89
Error	102	3098.45	30.38	
Viewpoint	1	820.32	820.32	54.95 *
Gender x Viewpoint	1	92.51	92.51	6.19 *
Error	102	1522.60	14.93	

* $p < .05$

** $p < .001$

Benevolence

Gender and Viewpoint were statistically significant, $F(1, 102) = 6.54$, $p < .05$, and $F(1, 102) = 54.36$, $p < .001$, respectively. Overall women rated themselves more benevolent than men and all participants rated themselves as more benevolent than their ratings of others' benevolence. The interaction was also significant, $F(1, 102) = 6.51$, $p < .05$, indicating that women rated themselves as more benevolent than men rated themselves but both men and women rated others equally benevolent (see Table 4).Social Restrictiveness

Table 5 illustrates the statistical break down for the Social subscale. The Gender and viewpoint main effects were statistically significant $F(1, 102) = 5.37$, $p < .05$, and $F(1, 102) = 66.29$, $p < .001$, respectively. The Gender x Viewpoint interaction was also statistically significant for the Social restrictiveness subscale $F(1, 102) = 5.66$, $p < .05$. Participants rated themselves as less socially restrictive than their rating of others social restrictiveness. For the interaction women rate themselves and others as less restrictive than men rated themselves and others.

Community Mental Health Ideology

As with the authoritarian scale the Viewpoint main effect and the Gender X Viewpoint interaction were statistically significant for the Community Mental Health Ideology scale, $F(1, 102) = 49.86$, $p < .001$, and $F(1, 102) = 5.32$, $p < .05$, respectively (see Table 6). Men and women did not differ in their measure of others viewpoint.

Table 4

Gender by Viewpoint Analysis of Variance for Benevolence Subscale Scores

Source	df	SS	MS	F
Gender	1	223.08	223.08	6.54 *
Error	102	3476.88	34.09	
Viewpoint	1	1212.05	1212.05	54.33 *
Gender x Viewpoint	1	145.13	145.13	6.51 *
Error	102	2275.32	22.31	

* $p < .05$

** $p < .001$

Table 5

Gender by Viewpoint Analysis of Variance for Social Restrictiveness Subscale Scores

Source	df	SS	MS	F
Gender	1	202.79	202.79	5.37 *
Error	102	3854.73	37.79	
Viewpoint	1	1403.05	1403.05	66.29 **
Gender x Viewpoint	1	119.79	119.79	5.66 *
Error	102	2158.64	21.16	

* $p < .05$

** $p < .001$

Table 6

Gender by Viewpoint Analysis of Variance for Community Mental Health Ideology Subscale Scores

Source	df	SS	MS	F
Gender	1	133.27	133.27	2.55
Error	102	5337.91	52.33	
Viewpoint	1	1069.74	1069.74	49.86**
Gender x Viewpoint	1	114.24	114.24	5.32 *
Error	102	2188.37	21.45	

* $p < .05$

** $p < .001$

Because personal experience and contact with individuals with mental illness is known to impact perceptions and attitudes, a final analysis was done to check the impact of this extraneous variable. An independent t test looking at mean scores for those who reported previous personal therapy and those who reported no previous therapy was preformed on each of the four subscales. Those who had therapy ($n = 25$) were more benevolent than those who had not ($n = 79$), $t\,(102) = 2.10$, $p < .05$.

In summary, Hypothesis 1 and Hypothesis 2 which stated gender would not impact reported attitudes were not supported for this sample. Based on these data the hypothesis that reporting perspective would make a difference in attitudes reported was accepted. The potentially confounding variable of experience with or knowledge of mental illness does not appear to play a major role except in the level of benevolence reported.

CHAPTER 4

DISCUSSION

The goal of the study was to examine the effects of gender and viewpoint reported on the attitudes of college students toward individuals with mental illness. The purpose of examining attitudes was to increase our understanding of the social environment in which individuals with mental illness must live.

Hypotheses

Hypothesis 1. Hypothesis 1 predicted perceptions of people labeled mentally ill would differ depending on whether the individual reports personal views or the perceived views of others. Data analysis supported this prediction. Analysis showed that participants reported stronger personal attitudes than those they perceived others to posses. Personal attitudes also were reported as more tolerant than attitudes reported for others.

Hypotheses 2. Hypothesis 2 stated that gender of participants would not influence attitudes reported toward people with a mental illness. This hypothesis was not supported in the present study. Men and women differed significantly on the Community Attitudes toward Mental Illness (CAMI) scale on all 4 attitude subscales (authoritarianism, benevolence, social restrictiveness, and community mental health ideology [CMHI]) when they were rating themselves but not as they rated others. Authoritarianism is the view that people with mental illnesses need to be hospitalized and that it is easy to differentiate individuals with mental illness from normal people. Benevolence is the perspective that views society as responsible for providing care for individuals with mental illness and one's willingness to be personally involved. Social Restrictiveness is

the view about how dangerous people with mental illness are perceived to be and how much social distance from individuals suffering from a mental illness is wanted. Community Mental Health Ideology taps into views of how people with mental illness are to fit into communities and neighborhoods (Taylor & Dear, 1981). Consistent with earlier studies using the CAMI, women expressed more tolerant attitudes toward people with mental illness than men. One divergence from previous findings regarding gender effects was that women reported significantly higher levels of authoritarianism than men. This is the reverse of most previous findings; typically, men report more authoritarian attitudes than women. Given the overall tendencies for women to be more tolerant and view individuals with mental illness more favorably, replications of the above finding are needed to rule out sample specific results. Previous research (Brockington et al., 1993; Wolff et al., 1996) found women to hold more authoritarian attitudes when they had children. Whether women in the present study had children is not known.

Hypothesis 3. Gender interaction results regarding response viewpoint contradicted the third hypothesis that gender would not make a difference. Women and men differed in reporting their personal opinions, but did not differ significantly when reporting what they perceived to be the viewpoint of others. In addition, there were significant differences between genders on viewpoint reported. Consistent with the hypothesis set forth by Aubry et al. (1995) and Socall and Holtgaves (1992), personal attitudes were more tolerant than the perceived attitudes of others. This difference suggests participants may have been influenced by the social desirability effect. Women showed greater differences between their personal view and their perception of the views held by others than did the men. The greater gap between viewpoint reported for women

is challenging to interpret. It may indicate a greater desire on the part of the women to appear more tolerant than others, it may reflect the general tendency for women to have attitudes that are more tolerant, or a combination of the two.

There were no significant differences between men and women regarding their report of the perceived attitudes of others. The lack of a gender difference indicates gender may not influence how one assesses the attitudes of others. Women's scores were higher than men's scores on all scales except that of authoritarianism. Although the differences were not significant the trend for women to have attitudes that are more tolerant was maintained for three of the scales. There were significant gender differences when reporting their own attitudes. Thus, it can be cautiously inferred that gender affects the report of personal attitudes, but not one's perception of the views of others.

Implications

The implications of these findings are important on a number of different issues. They are important when considering the increased numbers of people with mental illness in communities since the passage of 'The Federal Community Mental Health Center Act." Given some evidence in previous research for a decrease in the influence of gender on attitudes replication and expansion of this studies results is necessary. In this study the continued presence of gender differences suggests efforts to educate communities about mental illness may need to modify programs to incorporate this difference. For professionals, treatment plans and interventions on behalf of a client within a community may need further specification depending on the gender distribution of individuals with which the mentally ill person is interacting.

The significant effects in this study also indicate a continued lack of knowledge about mental illnesses. Women's scoring high on the authoritarian scale indicates a difference not found in previous research (Vera & Range, 1988). First, this finding needs to be replicated. If further studies demonstrate this same tendency the implication is potential increase in the "Not in my Backyard" attitude found by Arens (1993) and Wolff et al. (1996). This also may indicate the increased tolerance found in Pomberg's (1998) study is limited. It may be plausible to speculate that despite the trend of women to be more benevolent, fear of the violent aggressive mentally ill stereotype created by the media may lead women to be increasingly authoritarian.

Desforges et al. (1991) and Drolen (1993) both reported that the type of interactions people had with members of a stigmatized group impacted attitudes more than simple exposure to the group. The significant difference in levels of benevolence found between those who had had personal therapy and those who had not supports the idea that it is the type of contact and how personal the interactions are with people from stigmatized groups that impacts attitudes. Those who had experienced therapy at a personal level appear more willing to be personally involved and believe that society has a responsibility to help care for those with mental illnesses. Regardless of what issues drew the 25 individuals from the sample into therapy the experience appears to have impacted the degree of benevolence they hold toward people with mental illnesses.

Limitations and Future Directions

There were a number of limitations to this study. First, the lack of diversity of the sample limits the population to which the results can be generalized. College-age, students from small midwestern universities constitute a population that may not be

critical to understand in order to better anticipate the needs of someone with mental illness and the attitudes they will encounter. An expansion to include varied age groups and individuals that may be employing or renting housing to individuals with mental illness would be more practically useful.

A second limitation is the limited range of attitudes that are assessed through self-report measures. Constructs such as social desirability do impact responses. Reporting of attitude only provides information about what people report to believe and does not assess whether the attitudes are consistent with behavior or not. For example, that women report a more benevolent attitude than men does not foretell the degree of benevolence with which women actually treat those with mental illness.

Socall and Holtgraves (1992) suggest assessing the difference between one's personal attitudes and the perception of the attitudes of others provides a measure of how much of personal attitude reported may be effort to portray oneself as "better" than others. In this study there were differences for both men and women. If Socall and Holtgraves hypothesis holds true and personal attitudes are closer to those reported as perceived attitudes of others, conclusions drawn from self-reported attitudes are not accurate. Given that a significant difference was found for this sample between personal and perceived viewpoint of others, and the gender differences regarding personal attitude but not the perceived attitudes of others, the variance accounted for by the gender difference maybe smaller than it appears.

Another factor that may have impacted the results is the format of the questionnaire. The participants were asked to answer the questions twice on the same questionnaire and they may have had some expectation that the answers should be

different. A comparison study using formats that measure attitudes concurrently as this study did as well as alternately (i.e., asking participants to respond to the questionnaire at two separate intervals alternating which viewpoint they use to respond, personal or perceived view of others attitudes), would help clarify the significance of the difference found between personal attitude and perceived attitudes of others.

A detailed description of mental illness or examples of behaviors such as videos would also provide a clearer picture of attitudes that exist toward mental illness. In this study, participants were simply given the questionnaire and no description of mental illness was provided. What constituted mental illness probably differed among participants. One individual may have imagined a mentally ill person as someone demonstrating severely disturbed behaviors such as hallucinations and another person may have perceived a person with mental illness to be anyone that seeks help from a therapist. These variations in definition and knowledge of mental illness may have impacted the results. Farina et al. (1996) found that how mental illness was defined impacted attitudes based on different socioeconomic levels, so defining mental illness before asking people to respond to the questionnaire may influence the reported attitudes.

Based on the limitations described further research is encouraged. Future research should include larger samples and samples from non-college populations. A more descriptive definition of mental illness, and use of more than one attitude measure are also suggested to enhance the understanding of attitudes toward people with mental illness. Furthermore, including past experience with mental illness as a factor is important, this study did not control for this variable it only gauged to see if there was an impact.

This study found that attitudes toward people with mental illnesses do vary with gender and how attitudes are reported impact what is reported. Because of this variation further research is necessary to continue to assess changes that may occur in general attitudes toward mental illness as well as to help understand the social environment in which people with mental illness must exist.

REFERENCES

Arens, D. A. (1993). What do the neighbors think now? Community residences on Long Island New York. Community Mental Health Journal, 29, 235-245.

Aubry, T. D., Tefft, B. & Carrie, R. F. (1995). Public attitudes and intentions regarding tenants of community mental health residences who are neighbours. Community Mental Health Journal, 31, 39-52.

Baker, F., & Schulberg, H. (1967). The development of a community mental health ideology scale. Community Mental Health Journal, 3, 216-225.

Brockington, I.F., Hall, P., Levings, J., & Murphy, C. (1993). The community's tolerance of the mentally ill. British Journal of Psychiatry, 162, 93-99.

Cohen, J., & Struening, E. L. (1962). Opinions about mental illness in the personnel of two large mental hospitals. Journal of Abnormal and Social Psychology, 64, 349-360.

Deforges, D. M., Lord, C. G., Ramsey, S. L., Mason, J. A., Van Leeuwen, M. D., West, S. C., & Lepper, M. R. (1991). Effects of structured cooperative contact on changing negative attitudes toward stigmatized social groups. Journal of Personality and Social Psychology, 60, 531-544.

Drolen, C. S. (1993). The effect of educational setting on student opinions of mental illness. Community Mental Health Journal, 29, 223-234.

Farina, A., Felner, R., & Boudreau, L. (1973). Reactions of workers to male and female mental patient job applicants. Journal of Consulting and Clinical Psychology, 41, 363-372.

Farina, A., Fischer, E. H., Boudreau, L. A., & Belt, W. E. (1996). Mode of target presentation in measuring the stigma of mental disorder. Journal of Applied Social Psychology, 26, 2147-2156.

Flynn, L. M. (1987). The stigma of mental illness. New Directions for Mental Health Services, 34, 53-60.

Hall, P., Brockington, I. F., Levings, J., & Murphy, C. (1993). A comparison of responses to the mentally ill in two communities. British Journal of Psychiatry, 162, 99-108.

Lyons, M., & Hayes, R. (1993). Student perceptions of persons with psychiatric and other disorders. The American Journal of Occupational Therapy, 47, 541-547.

Malla, A., & Shaw, T. (1987). Attitudes towards mental illness: The influence of education and experience. The International Journal of Social Psychiatry, 33, 33-41.

Mangum, P. D., & Mitchell, K. M. (1973). Attitudes toward the mentally ill and community care among professionals and their students. Community Mental Health Journal, 9, 350-353.

Ojanen, M. (1992). Attitudes towards mental patients. The International Journal of Social Psychiatry, 38, 121-130.

Pomberg, A. (1998). An examination of the effects of gender on attitudes toward people with mental illness among college students. Unpublished master thesis, Emporia State University, Emporia, KS.

Purvis, B., Brandt, R., Rouse, C., Vera, W., & Range, L. M. (1988). Students' attitude toward hypothetical chronically and acutely mentally and physically ill individuals. Psychological Reports, 62, 627-630.

Reda, S. (1996). Public perceptions of former psychiatric patients in England. Psychiatric Services, 47, 1253-1255.

Roy, P. G., & Storandt, M. (1989). Older adult's perceptions of psychopathology. Psychology and Aging, 4, 369-371.

Shokoohi-Yekta, M., & Retish, P. M. (1991). Attitudes of Chinese and American male students towards mental illness. The International Journal of Social Psychiatry, 37, 192-200.

Skinner, L.J., Berry, K. K., Griffith, S. E., & Byers, B. (1995). Generalizability and specificity of the stigma associated with the mental illness label: A reconsideration twenty-five years later. Journal of Community Psychology, 23, 3-17.

Socall, D. W., & Holtgraves, T. (1992). Attitudes toward the mentally ill: The effects of label and beliefs. The Sociological Quarterly, 33, 435-445.

Taylor, S. M., & Dear, M. (1981). Scaling community attitudes toward the mentally ill. Schizophrenia Bulletin, 7, 225-239.

Urdaneta, M. L., Saldana, D.H., & Winkler, A. (1995). Mexican-American perceptions of severe mental illness. Human Organization, 54, 70-77.

Wahl, O. F., & Kaye, A. L. (1992). Mental illness topics in popular periodicals. Community Mental Health Journal, 28, 21-28.

Whaley, A.L. (1997). Ethnic and racial differences in perceptions of dangerousness of persons with mental illness. Psychiatric Services, 48, 1328-1330.

Wolff, G., Pathare, S., Craig, T., & Leff, J. (1996a). Community Attitudes to mental illness. British Journal of Psychiatry, 168, 183-190.

Wolff, G., Pathare, S., Craig, T., & Leff, J. (1996b). Community knowledge of mental illness and reaction to mentally ill people. British Journal of Psychiatry, 168, 191-198.

Appendix A

Participation Consent Form

Read this consent form. If you have any questions ask the experimenter and he will answer the question.

You are invited to participate in a study investigating attitudes and perceptions of individuals suffering from a mental illness. Information obtained in this study will be identified only by code number. Your name will be used only to indicate that you participated in the study and received research points for participating.

Your participation in this study is voluntary. Should you wish to terminate you participation, you are welcome to do so at any point in the study. There is no risk or discomfort involved in completing the study.

If you have any questions or comments about this study, feeling free to ask the experimenter. If you have any additional questions, please contact Michael James, 343-7522. Thank you for your participation.

I, _____, have read the above information and have decided to participate.

(Please print name)

I understand that my participation is voluntary and that I may withdraw at any time without prejudice after signing this form should I choose to discontinue participation in this study.

_____ _____

(Signature of participant) (Date)

Appendix B

Demographic Profile

1. Age: _____

2. Gender: M F
(Circle one)

3. Education : _____ Student Status: Traditional Nontraditional

4. Major: _____ (Circle one)

5. Classes in Psychology/social work or counseling:
None List:
_____

6. Average household income per year:
15, 000 or below; 15,000- 25,000; 25,000-50, 000; over 50,000

7. Have you ever used any type of mental health services? Yes No
(Mental health service can include: therapist, counselor, psychologist, psychiatrist etc.)

8. Have you known or do you know somebody with a mental illness or who has used any type of mental health service? (Mental health service can include: therapist, counselor, psychologist, psychiatrist etc.)
Yes No
If yes how close: Family Friend Acquaintance

Appendix C

COMMUNITY ATTITUDES TOWARD THE MENTALLY ILL SCALE

In the first column circle the letter that best corresponds to your personal opinion. In the second column circle the letter the best corresponds to how you feel others would respond to the question.

SA = strongly agree
A = agree
N = neither agree or disagree
DA = disagree
SDA =strongly disagree

1. Mental illness is an illness like any other.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

2. The mentally ill don't deserve our sympathy.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

3. Mental health facilities should be kept out of residential neighborhoods.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

4. The mentally ill should not be denied their individual rights.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

5. One of the main causes of mental illness is a lack of self-discipline and will power.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

6. The mentally ill are a burden on society.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

7. Residents should accept the location of mental health facilities in their neighborhood to serve the needs of the local community.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

8. Mental patients should be encouraged to assume the responsibilities of a normal person.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

9. The best way to handle the mentally ill is to keep them behind locked doors.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

10. The mentally ill have for too long been the subject of ridicule.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

11. The best therapy for many mental patients is to be part of a normal community.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

12. The mentally ill should not be given any responsibility.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

13. The mentally ill should not be treated as outcasts of society.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

14. Increased spending on mental health services is a waste of tax dollars.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

15. As far as possible, mental health services should be provided through community based facilities.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

16. The mentally ill should be isolated from the rest of the community.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

17. Less emphasis should be place on protecting the public from the mentally ill.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

18. More tax money should be spent on the care and treatment of the mentally ill.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

19. Local residents have good reasons to resist the location of mental health services in their neighborhoods.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

20. A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

21. There is something about the mentally ill that makes it easy to tell them from normal people.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

22. We need to adopt a far more tolerant attitude toward the mentally ill in our society.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

23. Locating mental health services in residential neighborhoods does not endanger local residents.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

24. I would not like to live next door to a person who has been mentally ill.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

25. Mental hospitals are an outdated means of treating the mentally ill.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

26. Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

27. Having mental patients living within residential neighborhoods might be good therapy but the risks to residents are too great.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

28. Anyone with a history of mental problems should be excluded from taking public office.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

29. Virtually anyone can become mentally ill.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

30. There are sufficient existing services for the mentally ill.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

31. It is frightening to think of people with mental problems living in residential neighborhoods.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

32. The mentally ill are far less of a danger than most people suppose.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

33. As soon as a person shows signs of mental disturbance, he/she should be hospitalized.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

34. We have a responsibility to provide the best possible care for the mentally ill.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

35. Locating mental health facilities in a residential area downgrades the neighborhood.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

36. No one had the right to exclude the mentally ill from their neighborhood.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

37. Mental patients need the same kind of control and discipline as a young child.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

38. It is best to avoid anyone who has mental problems.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

39. Most women who were once patients in a mental hospital can be trusted as babysitters.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

40. Residents have nothing to hear from people coming into their neighborhood to obtain mental health services.

You	Other
SA-----A-----N-----DA-----SDA	SA-----A-----N-----DA-----SDA

Permission to Copy Page

I, Michael James, hereby submit this thesis to Emporia State University as partial fulfillment of the requirements for an advanced degree. I agree that the Library of the University may make it available for use in accordance with its regulations governing materials of this type. I further agree that quoting, photocopying, or other reproduction of this document is allowed for private study, scholarship (including teaching) and research purposes of a nonprofit nature. No copying which involves potential financial gain will be allowed without written permission of the author.

Michael James

Signature of Author

06-02-01

Date

Investigation of Attitudes Toward People with Mental Illness

Title of Thesis

Joy Cooper

Signature of Graduate Office Staff Member

August 6, 2001

Date Received