7-1-1989

A comparison of the attitudes of medical social workers and mental health social workers toward mental illness

Sandra E. Wilson
Clark Atlanta University

Follow this and additional works at: http://digitalcommons.auctr.edu/dissertations

Part of the Social Work Commons

Recommended Citation

This Dissertation is brought to you for free and open access by DigitalCommons@Robert W. Woodruff Library, Atlanta University Center. It has been accepted for inclusion in ETD Collection for AUC Robert W. Woodruff Library by an authorized administrator of DigitalCommons@Robert W. Woodruff Library, Atlanta University Center. For more information, please contact cwiseman@auctr.edu.
A COMPARISON OF THE ATTITUDES OF
MEDICAL SOCIAL WORKERS AND MENTAL HEALTH SOCIAL WORKERS
TOWARD MENTAL ILLNESS

A DISSERTATION
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF DOCTOR OF PHILOSOPHY

BY
SANDRA E. WILSON

SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA
JULY 1989
ABSTRACT
SOCIAL WORK

WILSON, SANDRA E.

A COMPARISON OF THE ATTITUDES OF MEDICAL SOCIAL WORKERS AND MENTAL HEALTH SOCIAL WORKERS TOWARD MENTAL ILLNESS

Advisor: Dr. Richard Lyle
Dissertation dated July, 1989

The purpose of this study was to compare the attitudes of medical social workers (MSWs) and mental health social workers (MHSWs) toward mental illness. The sample consisted of 87 subjects, 56 MSWs and 31 MHSWs.

The instrument utilized was the Opinions About Mental Illness Scale which measured five attitudinal factors: Authoritarianism, Benevolence, Mental Hygiene Ideology, Social Restrictiveness and Interpersonal Etiology. Data was analyzed, using Pearson's r. No significant differences were found on the Authoritarianism dimension. However, MSWs scored higher on Benevolence, Mental Hygiene Ideology, Social Restrictiveness, and Interpersonal Etiology as compared to MHSWs. One of the most significant implications was that the clinical environment should be less physically and socially restrictive so that the patient would not feel as though s/he was in prison and had committed a crime.
Acknowledgments

The author wishes to express thanks to the Dissertation Committee and Chair, Dr. Richard Lyle for valuable advice and support. A special thanks to Dr. Gaylene Perrault for her long hours of consultation and reading of drafts, and for the emotional support given. To my mother, Mrs. Anne L. Wilson and my aunt, the late Mrs. Minnie M. Hopkins, very special love and appreciation are expressed. They have been a source of inspiration, and were always supportive throughout my academic endeavors.
Table of Contents

<table>
<thead>
<tr>
<th>Acknowledgments</th>
<th>ii</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of Tables</td>
<td>v</td>
</tr>
<tr>
<td>List of Appendices</td>
<td>vii</td>
</tr>
<tr>
<td>CHAPTER</td>
<td></td>
</tr>
<tr>
<td>I. Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Purpose of the Study</td>
<td>2</td>
</tr>
<tr>
<td>Review of Literature</td>
<td>2</td>
</tr>
<tr>
<td>Review of Related Research</td>
<td>17</td>
</tr>
<tr>
<td>Need for the Study</td>
<td>29</td>
</tr>
<tr>
<td>Study Hypotheses</td>
<td>30</td>
</tr>
<tr>
<td>II. Methods</td>
<td>32</td>
</tr>
<tr>
<td>Site</td>
<td>32</td>
</tr>
<tr>
<td>Setting</td>
<td>32</td>
</tr>
<tr>
<td>Subject Pool/Sample</td>
<td>32</td>
</tr>
<tr>
<td>Instrument</td>
<td>33</td>
</tr>
<tr>
<td>Item Response Set</td>
<td>34</td>
</tr>
<tr>
<td>Procedure</td>
<td>34</td>
</tr>
<tr>
<td>Data Collection</td>
<td>34</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>35</td>
</tr>
<tr>
<td>Human Subjects Contract</td>
<td>35</td>
</tr>
<tr>
<td>III. Results</td>
<td>37</td>
</tr>
<tr>
<td>Demographic Profile</td>
<td>37</td>
</tr>
<tr>
<td>Survey Results</td>
<td>50</td>
</tr>
<tr>
<td>Authoritarianism</td>
<td>50</td>
</tr>
<tr>
<td>Benevolence</td>
<td>62</td>
</tr>
<tr>
<td>Mental Hygiene Ideology</td>
<td>77</td>
</tr>
<tr>
<td>Social Restrictiveness</td>
<td>88</td>
</tr>
<tr>
<td>Interpersonal Etiology</td>
<td>99</td>
</tr>
<tr>
<td>IV. Discussion</td>
<td>111</td>
</tr>
<tr>
<td>Authoritarianism</td>
<td>112</td>
</tr>
<tr>
<td>Benevolence</td>
<td>117</td>
</tr>
<tr>
<td>Mental Hygiene Ideology</td>
<td>124</td>
</tr>
<tr>
<td>Social Restrictiveness</td>
<td>130</td>
</tr>
<tr>
<td>Interpersonal Etiology</td>
<td>135</td>
</tr>
<tr>
<td>Implications</td>
<td>142</td>
</tr>
</tbody>
</table>
List of Tables

2.0....Activities Employed In Phases Of The Study........................................36

3.0a...Demographic Profile Of Aggregate Sample: Race, Sex, Age, And Degree In Numbers (#), And Percents (%) (N=87)......................38

3.0b...Demographic Profile Of Aggregate Sample: Marital Status, Income Status, Training Setting, And Experience In Numbers (#), And Percents (%) (N=87)......................39

3.1a...Demographic Profile Of Medical Social Workers (MSWs) Subsample: Race, Sex, Age, And Degree In Numbers (#), And Percents (%) (N=56)........................................40

3.1b...Demographic Profile Of Mental Health Social Workers (MHSWs) Subsample: Race, Sex, Age, And Degree In Numbers (#), And Percents (%) (N=31) .........................41

3.2a...Demographic Profile Of Medical Social Workers (MSWs) Subsample: Marital Status, Income Status, Training Setting, And Experience In Numbers (#), And Percents (%) (N=56)........................................44

3.2b...Demographic Profile Of Mental Health Social Workers (MHSWs) Subsample: Marital Status, Income Status, Training Setting, And Experience In Numbers (#), And Percents (%) (N=31) .........................45

3.3a...Responses On The Authoritarianism Dimension For Subsample One (MSWs) And Subsample Two (MHSWs) In Numbers (#), And Percents (%) (N=87).................................53

3.3b...Report Of Means (X), Standard Deviations (s), Variances (s²), Probability (p), And Pearson's r (r) From The Authoritarianism Dimension For Subsample One (MSWs) And Subsample Two (MHSWs) (N=87).........................63

3.4a...Responses On The Benevolence Dimension For Subsample One (MSWs) And Subsample Two (MHSWs) In Numbers (#), And Percents (%) (N=87).................................66
3.4b...Report Of Means (\(\overline{X}\)), Standard Deviations (s), Variances (s^2), Probability (p), And Pearson's r (r) From The Benevolence Dimension For Subsample One (MSWs) And Subsample Two (MHSWs) (N=87)..................77

3.5a...Responses On The Mental Hygiene Ideology Dimension For Subsample One (MSWs) And Subsample Two (MHSWs) In Numbers (#), And Percents (%) (N=87).................................80

3.5b...Report Of Means (\(\overline{X}\)), Standard Deviations (s), Variances (s^2), Probability (p), And Pearson's r (r) From The Mental Hygiene Ideology Dimension For Subsample One (MSWs) And Subsample Two (MHSWs) (N=87).............88

3.6a...Responses On The Social Restrictiveness Dimension For Subsample One (MSWs) And Subsample Two (MHSWs) In Numbers (#), And Percents (%) (N=87).................................91

3.6b...Report Of Means (\(\overline{X}\)), Standard Deviations (s), Variances (s^2), Probability (p), And Pearson's r (r) From The Social Restrictiveness Dimension For Subsample One (MSWs) And Subsample Two (MHSWs) (N=87).............100

3.7a...Responses On The Interpersonal Etiology Dimension For Subsample One (MSWs) And Subsample Two (MHSWs) In Numbers (#), And Percents (%) (N=87).................................102

3.7b...Report Of Means (\(\overline{X}\)), Standard Deviations (s), Variances (s^2), Probability (p), And Pearson's r (r) From The Interpersonal Etiology Dimension For Subsample One (MSWs) And Subsample Two (MHSWs) (N=87).............109

3.8....Report Of Significance On Five Dimensions Of The Opinions About Mental Illness Scale And Related Hypotheses.........................110
<table>
<thead>
<tr>
<th>List Of Appendices</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix A...Opinions About Mental Illness Survey</td>
<td>149</td>
</tr>
<tr>
<td>Appendix B...Administrative Contract</td>
<td>161</td>
</tr>
</tbody>
</table>
CHAPTER I

Introduction

In society, attitudes toward the mentally ill and mental illness have led to the mentally ill being stigmatized and stereotyped. These attitudes are not only held by the general public, they are also held by some members of the helping professions, which include physicians, nurses and social workers. The attitudes of helping professionals toward mental illness is significant, since these attitudes may have an impact on patient care. There have been studies that concluded these findings (Cohen & Struening, 1964 and Ellsworth, 1965).

The attitudes of social workers toward mental illness may influence the care that mentally ill patients receive. People tend to feel that social workers are a homogeneous group. However, this may not be true, since medical and mental health social workers are trained from different perspectives. In patient care, it may be assumed that medical social workers (MSWs) rely on the disease model, whereas mental health social workers (MHSWs) rely on a model that is blame oriented. One may assume that mental health social workers have more positive attitudes toward mental illness. However, this also may not be true. Therefore, an investigation of theory and related research is in order.
Purpose Of The Study

The purpose of this study was to compare the attitudes of medical social workers (MSWs) and mental health social workers (MHSWs) toward mental illness.

Chapter One consists of an introduction to the study, purpose of the study, review of literature and related research, need for the study, and hypotheses. Also, included are operational definitions and variables that are under study.

Chapter Two details the methodology utilized in the study, and statistical procedures that were employed.

Chapter Three presents statistical data of the variables under study.

Chapter Four contains a discussion of the findings, with implications for social work practice and training, and future research.

Review Of Literature

This review of literature is concerning attitudes, attitudes and behavior, and labeling. When these concepts are applied to those in the helping professions, they have an impact on patient care. Therefore, it is important that they are examined. These concepts are operationally defined and discussed below.

Attitudes

In the literature, there are several definitions of attitudes. Allport (1935), a social psychologist, offered a classic and comprehensive conception of attitudes. He
stated that an attitude is a state of mental alertness, developed through experience, resulting in a dynamic impact upon an individual's reaction to related objects and situations.

Allport (1935) also commented that an attitude prompts behavior that can be conducive or unfavorable, positive or negative concerning an object. This bipolarity has been regarded as the most significant feature in attitudes. From Allport's (1935) definition, it is important to note that an attitude is formulated through experience and makes influences on the object to which it pertains. This demonstrates the significance of attitudes.

According to Fishbein and Ajzen (1975), an attitude is a learned inclination to react in a consistently positive or negative way with regards to an object. This conceptualization which parallels Allport's (1935) definition conveys the contention that attitudes are learned. In a view similar to Allport (1935), Fishbein and Ajzen (1975) argued that attitudes are developed through prior conditioning; three steps complete this process. Initially, an individual has beliefs about an object based on its characteristics. Secondly, connected with each characteristic is an evaluative response or attitude. Finally, this attitude is reinforced through conditioning.

In discussing the relationship between attitudes and beliefs, Rokeach (1976) felt that it is crucial to differentiate between beliefs and attitudes before a
A definition of attitudes can be clearly understood. He stated that a belief is a single predisposition toward an object. This belief may be fact or fiction, accurate or inaccurate, viewed as positive or negative or suggest a specific action. Regardless of the content, beliefs are inclinations to action. An attitude is a framework of beliefs predisposed to action pertaining to an object. Further, it prompts an individual to react in a preferential way.

In an approach to the development of attitudes, McGuire (1969) postulated that attitudes exist because they can serve functions. Specifically, he proposed four functions that attitudes serve. They are described as follows:

1. **Utilitarian or Adaptive Function** - the attitude has some usefulness in helping achieve certain goals. For example, if an individual desired to be included in a certain group, s/he would adopt the attitudes held by the group's members. This person would have a greater chance of being accepted by the group.

2. **Economy or Knowledge Function** - the attitude plays a part in an individual's ability to organize his/her perception of others. Even though each person is different, similar characteristics allow us to categorize them. The individual can then react to a person
depending upon his/her assumption about their respective category.

3. **Expressive, Self-Realizing Function** - the attitude assists in projecting a suitable self-image. By verbalizing certain views that s/he would not tolerate, this person may appear decisive and determined.

4. **Ego-Defensive Function** - the attitude acts as a defense mechanism. If an individual engages in illicit behavior, s/he voices a strong dislike for habits that seem more detrimental, making his/her behavior appear less illicit.

From the four functions reviewed above, the economy or knowledge function perhaps illustrates best a purpose for an individual's attitudes toward mental illness. Someone labeled mentally ill will be perceived with respect to the mentally ill label. Therefore, the response toward the mentally ill person may be favorable or unfavorable, depending upon the individual's attitudes toward mental illness.

In summary, there are several definitions of attitudes. However, it appears that attitudes are established through experience and prompts someone to react in a preferential way. A person's attitudes with regards to mental illness are established through experience or social interaction and
these attitudes prompt an individual to react in a certain manner toward the mentally ill.

Individuals may adopt attitudes because they can serve various functions. A person's attitudes toward mental illness may assist him/her in responding to an individual labeled mentally ill. It is necessary to explore the relationship between attitudes and behavior.

**Attitudes and Behavior**

The manner in which attitudes influence behavior is controversial. Some theorists believe that there is a relationship between attitudes and behavior, while other theorists suggest that this assertion is merely an assumption.

For example, Rajecki (1982) established that there is a relationship between attitudes and behavior. He suggested that stereotypes are the behavioral manifestations of attitudes. With regard to stereotypes, the author examined the influence of an attitude on the holder of this view, and how this attitude may affect the person seen as a stereotype.

To illustrate this, Rajecki (1982) reviewed the commonly held attitude that tall people are better than their short peers. This view serves the holder of the attitude by assisting him/her in making judgments about people. This reaction is mainfested in that taller people tend to obtain better positions, earn higher salaries and to win more political elections. The target of the stereotype,
the short person, may have poor self-esteem, as a result of being considered less desirable than his/her tall peers.

Moreover, the short person may perpetuate this stereotype through a self-fulfilling prophecy. Being consistently faced with this stereotype, the short person may accept this stereotype. In doing so, this individual may not strive to achieve his/her full potential believing that tall peers are more desirable than s/he is. This process is termed behavioral confirmation. It occurs when the holder of an attitude consistently directs that attitude to the target and produces the stereotyped behavior, even though the target may or may not have an inclination to behave in that way.

There is another view that challenges Rajecki's (1982) theory, by supposing that there is little or no relationship between attitudes and behavior. Wicker (1969) conducted an extensive literature review on studies which investigated the attitude-behavior relationship. He highlighted over thirty separate attitude studies which concluded either weak correlations linking attitudes and behavior or none at all. This finding shows that inconsistencies may exist concerning the influence of an individual's attitude on his/her behavior, and that attitudes may not influence behavior.

Berkowitz (1972) warned the reader not to become pessimistic about Wicker's (1969) findings and offered an explanation for attitude-behavior discrepency. He argued that in some attitude studies, some of the attitude-behavior
discrepancies can be attributed to methodological flaws. At times, the attitude apparatuses are not good, and may be vulnerable to many external influences present in the measurement setting. Furthermore, these measures may not be an accurate tool to assess the variables that they were intended to detect.

In a view similar to Rajecki (1982), Ajzen and Fishbein (1980) stated that attitudes and behavior are related. These authors contended that some attitude and behavior measurements have been inappropriate. It is essential for these measurements to be appropriate and correspond. When this occurs, there is a significant degree of consistency between attitudes and behavior. In summary, attitudes toward mental illness may affect the person labeled mentally ill. There are two schools of thought on the relationship between attitudes and behavior. One proposes that these variables are related in that attitudes influence behavior. The other contention is that there is a weak relationship between attitudes and behavior. There is a high degree of consistency in the attitude-behavioral relationship when these variables are measured appropriately. The attitudes that individuals have with regard to others may be attributed to labeling.

Labeling Theory

Other theorists have examined labeling theory (Bogdan & Taylor, 1987; Link, 1987). However, the theorist that has received the most recognition for focusing on mental illness
has been Scheff (1984). Scheff (1984) provided a sociological theory of mental illness which was termed labeling theory. This theory is based upon two conceptualizations, rule-breaking and deviance. He stated that rule-breaking refers to a group of acts, which are violations of social norms, and deviance refers to certain acts which have been publicly recognized and viewed as norm violations.

Rule-breaking is defined as a violation of socially prescribed behavior, or social norms. This violation occurs when an individual acts in a manner that is against social norms. However, all rule-breaking does not result in a person being labeled mentally ill. The violator may be described as ignorant, ill-mannered, criminal, or sinful. There is a group of terms for several norm violations, such as bad manners, crime, and drunkenness. Each term reflects the sort of norm and behavior that was violated.

However, there is a residue of violations which does not have a definitive label. These violations are concerned with decency and reality. These norms are implicit and most members of society would consider it inconceivable to violate them. These implicit norms are called residual rules, and violations of these norms are residual rule-breaking or residual deviance. Mental illness is included in this group, categorized as residual deviance. Mental illness is defined as a behavioral state characterized by
abnormal manners which are indicative of psychological distress (Dugger, 1975).

In this theory, Scheff (1984) developed nine propositions. They are listed below.

**Proposition 1:** Residual rule-breaking emerges from various sources.

**Proposition 2:** The occurrence of unrecognized residual rule-breaking is very high, in relation to the occurrence of known mental illness.

**Proposition 3:** Most residual rule-breaking ceases and is not serious.

**Proposition 4:** Stereotyped images of mental illness are conveyed in the formative years.

**Proposition 5:** The stereotypes of mental illness are continually reinforced, in usual social communication.

**Proposition 6:** Labeled deviants may be encouraged to accept the stereotyped role of a deviant.

**Proposition 7:** Labeled deviants are penalized when they try to change to healthier roles.

**Proposition 8:** When a residual rule-breaker is known publicly, the deviant is highly vulnerable and may acquire the role of the mentally ill as the only choice.

**Proposition 9:** For residual rule-breakers, labeling is one of the main causes of lifelong residual deviance.

The first three propositions deal with the origins, prevalence, and duration of mental illness. In Proposition 1, residual rule-breaking emerges from various sources.
Scheff (1984) stated that mental illness can originate from several sources. These sources can be psychological, organic, environmental stress, or food and sleep deprivation. Scheff (1984) contended that it is difficult to distinguish induced psychoses, resulting from laboratory experiments involving sleep deprivation and the use of mind altering drugs, from actual psychoses.

In Proposition 2, the occurrence of unrecognized residual rule-breaking is very high, in relation to the occurrence of known mental illness. Scheff (1984) maintained that some severe violations of rules are frequently not acknowledged. If this behavior is acknowledged, it is usually viewed as eccentricity. This rule-breaking behavior is rationalized, ignored, or unrecognized. Scheff (1984) has identified this lack of acknowledgment and rationalization as normalization.

In Proposition 3, most residual rule-breaking ceases and is not serious. Scheff (1984) felt that most psychiatric symptoms are temporary and are not reliable indicators that these symptoms will become chronic. In this precept, he referred to mental disturbances caused by external pressure, such as family problems, drugs, and fatigue. This residual rule-breaking is stabilized as mental illness, in other words, becomes chronic, due to society's reaction.

Propositions 4 and 5 pertain to the process by which individuals in society acquire beliefs about the mentally
ill and the manner in which these beliefs are reaffirmed. In Proposition 4, stereotyped images of mental illness are conveyed in the formative years. Schoff (1984) contended that individuals become aware of stereotyped images of mental illness during early childhood. These images are usually learned from their peers. In playing, many children frighten each other by saying that the "boogie man" will get them.

In Proposition 5, the stereotypes of mental illness are continually reinforced, in usual social communication. Scheff (1984) asserted that during adulthood, with more education about the medical concepts of mental illness, some of these stereotyped images are nullified, but many remain. These images are reaffirmed in the mass media and through social interaction with the mentally ill. This proposition holds similarities to Allport's (1935) definition of attitudes, in which it was stated that attitudes are established through experience.

The last four propositions concern the process in which the deviant role is accepted. In Proposition 6, labeled deviants may be encouraged to accept the stereotyped role of a deviant. According to Scheff (1984), physicians and other members of the helping professions reward the mentally ill for accepting this role; acknowledgment of illness is considered by helping professionals as insight and may cause greater interaction with patients and staff.
The next proposition demonstrated what may occur if an individual does not accept this role. In Proposition 7, labeled deviants are penalized when they try to change to healthier roles. Scheff (1984) argued that an individual that does not desire to remain in this role and attempts to perform in healthier roles may receive negative sanctions. For example, individuals that admit to a history of psychiatric treatment may be discriminated against when attempting to secure employment even though their behavior is indistinguishable from others viewed as 'normal'.

In Proposition 8, when a residual rule-breaker is known publicly, the deviant is highly vulnerable and may acquire the role of the mentally ill as the only choice. Scheff (1984) stated that when extreme rule-breaking becomes publicly recognized, the rule-breaker may be very confused and anxious. In this state, the individual is vulnerable, and therefore, highly suggestible. The deviant may display behavior that is expected of him/her by others, as evidenced by their treatment of the rule-breaker. People react to residual rule-breakers based upon their attitudes toward mental illness. The rule-breaker is also familiar with these images since s/he, as did those responding to him/her, learned these stereotypes in childhood. The rule-breaker begins to identify with these stereotypes. Moreover, with validation of the role by psychiatrists and society, this individual may accept this role and become chronic.
This proposition parallels the process that Rajecki (1982) termed behavioral confirmation. According to Scheff (1984), when a person is publicly labeled mentally ill, this individual is distressed and highly suggestible. This individual may exhibit behavior that is expected of him/her by others. People react to this individual based upon their attitudes toward mental illness. It becomes a self-fulfilling prophecy, in that this person begins to identify with stereotypes of mental illness and behaves in the expected manner. This is detrimental because it may cause the mentally ill person to become chronic.

In Proposition 9, for residual rule-breakers, labeling is one of the main causes of lifelong residual deviance. Scheff (1984) asserted that if residual rule-breaking does not cause an individual to accept the sick role, then this person will not become chronic. However, if this individual accepts this label, then s/he will remain in this role and become chronic. In society, this person will receive negative sanctions, such as discrimination.

Scheff's (1984) labeling theory provides the theoretical framework for this research. It has relevance for this study, especially Propositions 5 and 8. With regards to Proposition 5, as members of society, social workers were exposed to these stereotypes of mental illness. Even though, they may possess some medical knowledge about mental illness, they may still hold some stereotypical views and not be aware that these views are stereotypical.
In relation to Proposition 8, when social workers are confronted with someone publicly labeled mentally ill, the reaction may be based upon their attitudes toward mental illness which were formulated in part by society's stereotypical images. The treatment that the mentally ill person receives may be influenced by the social workers' attitudes toward mental illness.

Atwood (1982) argued that some mental health professionals, which include social workers, possess negative attitudes toward the mentally ill, and that the development of these attitudes were influenced by stereotypes. Clinicians, as members of society, were exposed to stereotypes of mental illness. In a view similar to Scheff's (1984) theory, Atwood (1982) contended that negative stereotypes may be learned in childhood. These stereotypes may include the view that mental illness is alien and disgraceful. It may then remain in the attitudes of adult professionals even though more accurate knowledge is acquired.

Moreover, Atwood (1982) felt that a patient's diagnosis may reinforce stereotypes. Clinicians have to consider a patient's diagnosis when treating him/her to insure that the treatment plan is appropriate. In a sense, diagnoses represent stereotypes, in that diagnostic categories are structured by grouping characteristics present in certain disorders. This forces the clinician to view the patient in light of these characteristics or the expected behavior.
In summary, Scheff's (1984) labeling theory has provided explanations as to how stereotypes of mental illness are created and reinforced in the minds of individuals in society. Further, for this study, it is crucial to note that individuals may respond to the mentally ill person based upon their attitudes toward mental illness. Clinicians' attitudes toward the mentally ill may be influenced by diagnostic labeling.

This review of literature examined attitudes, attitudes and behavior, and labeling theory and found that there are several definitions of attitudes. Attitudes are formulated through experience and cause an individual to respond in a preferential manner.

The attitudes that individuals hold toward mental illness may affect the person labeled mentally ill by encouraging behavior associated with this label thus producing a self-fulfilling prophecy. The attitude-behavioral relationship is controversial. Some theorists contended that attitudes influence behavior, while other theorists argued that there is a weak relationship between attitudes and behavior. Moreover, it was revealed that when measured appropriately, there is a high degree of consistency in the attitude-behavioral relationship.

A person's attitudes toward mental illness could be explained through labeling theory. Mental illness is viewed as a violation of the rules in society, and the violator is labeled deviant. In society, individuals reinforce this
role by expecting those labeled mentally ill to act in a certain manner. Individuals have these behavior expectations from stereotypes of mental illness learned during social interactions and through the media. Diagnostic labeling may have an impact upon clinicians' attitudes toward mental illness. Several studies have been conducted on the attitudes of helping professionals toward mental illness.

Review Of Related Research

While there is a scant body of literature that is pertinent to this study, there are several studies that have focused on helping professionals' attitudes toward mental illness. This review of related research is comprised of these studies.

Attitudes Toward Mental Illness

Cohen and Struening (1962) conducted a study on attitudes toward mental illness among hospital personnel. The researchers felt that this phenomenon was significant because a hospital employee's attitudes toward mental illness and the mentally ill may affect the care that mental patients receive. A 70 item questionnaire was developed and administered to 1194 hospital employees working in two large Veteran Administration psychiatric hospitals, one in the Northeast and the other in the Midwest.

The sample represented different levels and functions of personnel whose duties involved frequent contact with patients. It was determined that 51 of the questionnaire
statements were valid in distinguishing between opinions about mental illness. The questionnaire devised was named the Opinions About Mental Illness Scale. On this scale, five attitudinal factors toward mental illness were identified. These factors were: Authoritarianism, Benevolence, Mental Hygiene Ideology, Social Restrictiveness, and Interpersonal Etiology. They are described below.

Authoritarianism described the view that the mentally ill are perceived as unlike and inferior to 'normal' persons, and that they need coercive supervision.

Benevolence referred to the parental view toward the mentally ill and the feeling that they deserve kind treatment. This emerges from a moral perspective that promotes a type of Christian concern for unfortunates.

Mental Hygiene Ideology described the view that the mentally ill are similar to 'normal' individuals. There may be differences in degree, though not in type and that mental illness is similar to any medical illness.

Social Restrictiveness referred to the view that the mentally ill are menaces to society and that restrictions should be placed on them during and after hospitalization.

Interpersonal Etiology referred to the belief that mental illness is the result of poor interpersonal relationships, namely lack of parental concern during the childhood years.
Of the 1194 respondents, there were 19 social workers. It was found that social workers scored low on Authoritarianism, Social Restrictiveness and Interpersonal Etiology; and scored high on Benevolence and Mental Hygiene Ideology. Cohen and Struening (1962) also explored the relationship of demographic variables with each attitudinal factor. The findings were that education was negatively correlated to the Authoritarianism and Benevolence factors. Education was positively correlated with the Mental Hygiene Ideology and Interpersonal Etiology factors. There was no significant relationship between age and the Benevolence, Mental Hygiene Ideology, or Interpersonal Etiology factors; a weak relationship existed with the remaining factors. Sex was weakly related to the factor scores. Women showed higher scores on the Benevolence and Social Restrictiveness factors. With regard to Benevolence, the researchers believed that this is indicative of the cultural role of women. Further, it was noted that nurses were the occupational group that scored highest on this factor and a quarter to a third of the subjects were female. With regard to Social Restrictiveness, the authors felt that the women may have responded in the context of what would be expected of them if they were married to a mental patient.

These researchers conducted another study (Cohen & Struening, 1963) to determine whether or not there would be significant variations in occupational groups pertaining to their attitudes toward mental illness. Cohen and Struening
(1963) administered the Opinions About Mental Illness Scale to 7,701 workers in 19 occupational groups at 12 Veteran Administration psychiatric hospitals throughout the United States. Of the sample, 131 were social workers. In this study, the scale was also administered to an opportunity sample of 40 Veteran Administration chief psychologists, 111 clergymen and 396 citizens. The occupational groups were categorized into four clusters and one unclustered group. Significant findings were described as follows:

Cluster 1: White Collar Workers - This group included technical and clerical employees, nurses, activity therapists, dentists and nonpsychiatric physicians. This group scored relatively low on Authoritarianism and with the remaining factors, there was little variability with scores of the other occupational groups. However, the exception was that nurses scored high on the Benevolence factor.

Cluster 2: Blue Collar Workers - This cluster consisted of engineering staff (repair and maintenance), kitchen staff, supply workers, housekeeping and aides. In this cluster, there were some extremely negative attitudes toward mental illness. This group scored high on Authoritarianism and Social Restrictiveness, and low on Benevolence. The aides scored average on Benevolence, and lower on Authoritarianism than the other occupations in this cluster. Cohen and Struening (1963) concluded that this was due to education and experience. This finding does not subtract from the fact that aides held an authoritarian restrictive
view of the mentally ill. This is most significant since aides interact with mental patients on a daily basis and are involved in their treatment plan.

**Cluster 3: Nonmedical Mental Health Professionals**—This group was comprised of social workers and psychologists. This cluster had extremely positive attitudes toward mental illness. They scored low on Authoritarianism and Social Restrictiveness and high on Mental Hygiene Ideology and Interpersonal Etiology.

**Cluster 4: Clergymen**—This group scored low on Authoritarianism and Social Restrictiveness and high on the remaining factors.

**Unclustered Groups: Citizens and Psychiatrists**—The citizens scored similar to those of the White Collar Cluster, excepting that this group had a higher score on Mental Hygiene Ideology and Authoritarianism. The psychiatrists scored low on Authoritarianism and Social Restrictiveness and high on Mental Hygiene Ideology and Interpersonal Etiology.

In this study, it was found that social workers held a positive view toward the mentally ill, which is nonauthoritarian and permissive. The findings of the earlier study (Cohen & Struening, 1962) which included social workers, were similar to these findings. However, in the previous study (Cohen & Struening, 1962), social workers scored low on Interpersonal Etiology. The researchers did not address this difference in the study's findings.
Cohen and Struening (1964) utilized data from a previous study (Cohen & Struening, 1963) to determine whether or not a hospital's social atmosphere had any bearing on its effectiveness. Each of the 12 Veteran Administration hospitals that participated in the study were viewed separately on the results of the Opinions About Mental Illness Scale to define the hospital's social atmosphere. To measure the hospital's effectiveness, Cohen and Struening (1964) used the average number of days that its patients stayed in the community during periods of six and 12 months following their admission, thus the opposite of hospitalization time.

It was found that patients treated at hospitals in which the atmosphere was extremely authoritarian and restrictive spent less time in the community between admissions. It appears that these attitudes may have had a detrimental effect on some patients by impeding therapeutic changes. The researchers also found that in hospitals with an opposite social atmosphere, nonauthoritarian and nonrestrictive, patients spent more time in the community between admissions. Moreover, these hospitals also scored high on Mental Hygiene Ideology. Cohen and Struening (1964) concluded that these attitudes may foster better staff-patient relationships. This could result in effective long-term therapeutic changes for patients. This study indicates that staff attitudes may influence how effectively patients are treated for their return to the community.
To examine the relationship between staff attitudes toward mental illness and their behavior, Ellsworth (1965) administered the Opinions About Mental Illness Scale to 65 nurses and aides. Psychiatric patients were chosen to rate the perceived behavior of these nurses and aides. For inclusion in the study, patients were chosen on the basis of their ability to identify pictures of the nurses and aides on the ward. They were also screened with regard to their ability to perform a test involving the scoring of personality characteristics. There were 188 patients from 382 (or 49.2% of the aggregate patient load) that scored the behavior of nurses and aides, on a 55 item personality characteristics scale.

The major findings were that those nurses and aides that scored high on Social Restrictiveness were associated with dominating and restrictive behavior as viewed by their patients, and were noted to avoid patients. Specifically, the patients perceived these individuals as inconsiderate, rigid, impatient, and unable to understand and interact with patients.

Nurses and aides that scored high on Benevolence were perceived as somewhat distant, aloof, and not involved by their patients. These individuals behaved inconsistently with attitudes held. To explore this incongruence, interviews were conducted with this group. After these discussions, Ellsworth (1965) concluded that these persons may find it more comfortable to indulge and pacify patients.
This is an effort to temporarily reassure patients. However, the patients perceived true attitudes exhibited through actions, which were contradictory. This study illustrates the impact that staff attitudes may have on their behavior in interacting with patients.

The mentally ill prisoner is not only cared for by nurses and social workers but also by attendants who generally function as guards. Twomey and Kiefer (1972) investigated attitude changes after instructions in interpersonal relations for attendants (guards) in a prison hospital for the criminally insane. The researchers felt that this study was needed because the attitude and atmosphere conveyed by personnel can affect the patient toward a more therapeutic adjustment to the hospital.

There was a need to implement a training program in which guards would gain knowledge in human relations and basic patient care for paraprofessionals. The desired outcome was to foster changes in attitudes that would promote a sense of well-being among patients.

The learning objective was to arm participants with psychological strategies in dealing with patient needs, manipulations, and conflicts. The program involved lectures on communication and nursing concepts, role-playing, and field trips to other institutions to acquire more awareness of staff-patient dynamics.

There were 61 guards that participated in the training program. They were from a Midwestern mental hospital.
Their age range was 25-68, with the average age being 49. Half of the subjects had completed high school. It is assumed that the other half had less than a high school education. These guards were administered the Opinions About Mental Illness Scale prior to and after the 20 week training session.

There were significant differences noted in the guards' attitudes after the training program on four of the attitudinal factors. Specifically, there were significant increases in Benevolence, Mental Hygiene, and Interpersonal Etiology, and decreases in Social Restrictiveness. No significant differences among the guards' attitudes toward Authoritarianism was found.

After the training program, the guards reported less occurrence of confrontations with patients, and that the intervention strategies learned were effective in discouraging patients' maladaptive behavior. The researchers concluded that custodial employees can be trained in strategies that can increase their effectiveness in fostering the well-being of patient offenders. This study demonstrates that through education, attitudes towards the mentally ill can become more positive. This may also act to promote better patient care.

Kahn (1976) explored the relationship between nurses' opinions about mental illness and their years of psychiatric work experience. She asserted that a vital part of undergraduate psychiatric nursing experience is that
students should be exposed to attitudes toward mental illness which will promote good nursing care. Kahn (1976) commented that when treating the mentally ill, the nurse should not emphasize an authoritarian relationship and should not view mental illness as socially restrictive. She postulated that with long-term experience the psychiatric nurse may not maintain this positive orientation. To investigate this, the researcher wanted to make some comparisons between psychiatric nursing students, psychiatric nurses, and medical-surgical nurses.

The Opinions About Mental Illness Scale was administered to experimental groups of psychiatric nursing students (n = 11) after a 12 week rotation in psychiatry, to experienced psychiatric nurses (n = 8), and medical-surgical nurses (n = 8) were the control group. Kahn (1976) matched the psychiatric and medical-surgical nurses for age and education, and all three groups were identical in (female) gender.

For each group of experienced nurses, there were four nurses within the 20-25 age range, six nurses within the 26-30 age range, and six nurses within the 31-35 age range. In the nursing students group, ten were within the 20-25 age range, and one student was within the 31-35 age range. The subjects had completed or were completing a three-year diploma program. The psychiatric and medical-surgical nurses had at least one year experience on their respective units.
The findings revealed that psychiatric nurses held significantly more authoritarian opinions about mental illness than the other groups. Age was not seen as affecting the opinion differences. Because the age-matched medical-surgical nurses had similar scores as the nursing students, Kahn (1976) assumed that this indicated a shift in the opinions of the psychiatric nurses, from formerly held opinions, which resembled those of the medical-surgical and nursing student groups.

The three groups did not differ significantly on opinions reflecting Benevolence toward the mentally ill. The psychiatric nurses agreed significantly less with Mental Health Ideology as compared to the nursing students. Because of her experience, the more senior nurse may adhere less to Mental Health Ideology. Kahn (1976) warned that the influence of age cannot be discounted, since the age-matched medical-surgical nurses scored similar to the psychiatric nurses on this factor. The nursing students scored highest on opinions of Mental Hygiene Ideology.

For each group of experienced nurses, it was found that nurses (n = 6) within the 31-35 age range scored lowest on Mental Hygiene Ideology. The nurses (n = 6) within the 26-30 age range scored low on Mental Hygiene Ideology, while nurses (n = 4) within the 20-25 age range scored high on Mental Hygiene Ideology. These results indicate an age continuum. With increasing age, some concepts related to Mental Hygiene Ideology may be lessened or discarded.
However, only when there are additional years of psychiatric experience is this seen as making a significant difference.

The psychiatric nurses had a greater inclination to possess opinions that mirror Social Restrictiveness than the other groups. For the medical-surgical and student group, there was no significant relationship on this factor.

The psychiatric nurses agreed less to beliefs concerned with an Interpersonal Etiology of mental illness than did the other groups. Kahn (1976) asserted that this finding may be seen as either positive or negative depending upon the theoretical approach utilized in treating patients.

Kahn (1976) concluded that psychiatric work experience can alter opinions about mental illness from a positive to a negative view. She suggested that the stresses encountered on the psychiatric unit may cause this attitude change.

Kahn (1976) stated that there is a need for nursing educators to assist students in becoming cognizant of the stresses that can occur in the hospital environment. Also, one needs to determine how these pressures can be dealt with without resulting in attitude changes that may be detrimental to good nursing care. This suggestion is applicable to all members of the helping professions.

Kahn (1976) did not specify how many years of psychiatric work experience affects nurses' attitudes toward mental illness. To be included in the study, nurses were only required to have one year of experience on their respective units. It would have been more enlightening to
give the percentage of years of experience and to compare work years (in range form) to the attitudinal factors.

In summary, some members of the helping professions hold positive attitudes toward mental illness, while others possess negative views. These attitudes may influence the relationship between staff and patients, thus impacting on the effectiveness of the therapeutic process. The attitude differences may be influenced by various factors, including demographic variables, and years of psychiatric experience.

This review of related research examined studies on attitudes toward mental illness. There is a paucity of studies conducted on social workers' attitudes toward mental illness and its impact on labeling. Therefore, this review of related research also included studies on helping professionals' attitudes toward mental illness. From the findings summarized above for helping professionals, implications can be drawn to a more specific population, that of medical and mental health social workers. Hence, there is a need for more research on this population.

Need For The Study

Even though there have been studies on attitudes toward mental illness, using the Opinions About Mental Illness Scale, which included social workers in the sample, none have specifically examined social workers. Because of this, more studies utilizing this research instrument on the medical and mental health social worker population is sorely
needed, since such attitudes have been revealed in the literature to affect the entire arena of patient care.

**Study Hypotheses**

The following hypotheses were tested in investigating the stated purpose:

**Hypothesis One:** There will be a statistically significant difference between the attitudes of medical social workers (MSWs) and mental health social workers (MHSWs) toward mental illness on the Authoritarianism factor as measured by the Opinions About Mental Illness Scale.

**Hypothesis Two:** There will be a statistically significant difference between the attitudes of medical social workers (MSWs) and mental health social workers (MHSWs) toward mental illness on the Benevolence factor as measured by the Opinions About Mental Illness Scale.

**Hypothesis Three:** There will be a statistically significant difference between the attitudes of medical social workers (MSWs) and mental health social workers (MHSWs) toward mental illness on the Mental Hygiene Ideology factor.
Hypothesis Four: There will be a statistically significant difference between the attitudes of medical social workers (MSWs) and mental health social workers (MHSWs) toward mental illness on the Social Restrictiveness factor as measured by the Opinions About Mental Illness Scale.

Hypothesis Five: There will be a statistically significant difference between the attitudes of medical social workers (MSWs) and mental health social workers (MHSWs) toward mental illness on the Interpersonal Etiology factor as measured by the Opinions About Mental Illness Scale.
CHAPTER II

Methods

This study was descriptive in nature. It commenced on March 8, 1989 and terminated on March 22, 1989.

Site

The site was Atlanta, Georgia. Atlanta, Georgia is a large metropolitan urban area, with a racially heterogeneous population.

Setting

The setting consisted of a variety of work settings such as hospitals, agencies and clinics where MSWs and MHSWs were employed. The setting included three hospitals, two agencies and three clinics. Of the three hospitals surveyed, two were located in Northeast Atlanta, and one was in Southeast Atlanta. One agency was located in Southwest Atlanta, and the other was in Northwest Atlanta. Two clinics were located in Northwest Atlanta, while one was in Southwest Atlanta.

Subject Pool/Sample

The subject pool consisted of the universe of MSWs and MHSWs who were employed in various work settings in Atlanta, Georgia at the time of the study. The subjects were selected for inclusion in the study on the basis of their job titles, which were medical social worker (MSW) and mental health social worker (MHSW). The sample consisted of
all MSWs and MHSWs who were willing to participate in the study by completing the questionnaire. Fifty-six MSWs and 31 MHSWs were acquired in this manner as study respondents.

**Instrument**

The instrument utilized in this study was the *Opinions About Mental Illness Scale* which was adapted from Cohen and Struening (1963). This instrument was employed because it assessed attitudinal factors that the researcher was interested in examining.

On the adapted scale, there were two sections (A and B). **Section A** included items to acquire demographic data, it had eight items. Form One included a statement that pertained to MSWs, and Form Two included a statement that pertained to MHSWs.

**Section B** contained the Opinions About Mental Illness Scale, and had 51 items (see Appendix A). The scale measured five factors, which were Authoritarianism, Benevolence, Mental Hygiene Ideology, Social Restrictiveness, and Interpersonal Etiology. They are described below with the number of items that represents each factor on the scale.

**Authoritarianism** described the view that the mentally ill are perceived as unlike and inferior to 'normal' persons. It contained 11 items.

**Benevolence** referred to the parental view toward the mentally ill and the feeling that they deserve kind treatment. It contained 14 items.
Mental Hygiene Ideology described the view that the mentally ill are similar to 'normal' individuals and mental illness is similar to any medical illness. It contained nine items.

Social Restrictiveness referred to the view that the mentally ill are menaces to society, and that restrictions should be placed on them during and after hospitalization. It contained 10 items.

Interpersonal Etiology referred to the belief that mental illness is the result of poor interpersonal relationships, namely lack of parental concern during the childhood years. It contained seven items.

**Item Response Set**

There were six response alternatives. However, for this study's purpose, forced-choice alternatives were used. The item responses were strongly disagree (SD), disagree (D), agree (A), and strongly agree (SA). The responses were assigned the numerical values of one, two, three, and four respectively.

**Procedure**

The activities employed in executing this study were comprised of pre-research, research, and post-research phases (see Table 2.0).

**Data Collection**

All data were collected by the researcher.
Data Analysis

The data were analyzed using Pearson's r, Frequency Analysis, Measures of Central Tendencies, and Measures of Variability.

Human Subjects Contract

A human subjects contract was not necessary for this study. Since the subjects were completing a survey, there was no potential for harm.
Table 2.0 **Activities Employed In Phases Of The Study**

<table>
<thead>
<tr>
<th>Phases</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Research</td>
<td>Phoned the administrator/director and inquired about the number of medical and mental health social workers on staff.</td>
</tr>
<tr>
<td></td>
<td>Requested and obtained permission to administer questionnaires to social workers on staff.</td>
</tr>
<tr>
<td></td>
<td>Sent a follow-up letter to the administrator/director detailing an administrative contract of the agreements made during the phone conversations (see Appendix B).</td>
</tr>
<tr>
<td>Research</td>
<td>Arrived at the setting on the specified days and times.</td>
</tr>
<tr>
<td></td>
<td>Explained the study and verbally delivered instructions to the subjects.</td>
</tr>
<tr>
<td></td>
<td>Administered the instrument to the subjects in a designated room with adequate and comfortable seating, lighting, and comfort control.</td>
</tr>
<tr>
<td></td>
<td>Collected the completed questionnaires.</td>
</tr>
<tr>
<td>Post-Research</td>
<td>The study period was terminated. Data were compiled, analyzed, and written in the dissertation.</td>
</tr>
</tbody>
</table>
CHAPTER III

Results

The results of this study are presented in two sections. For example, Section A includes demographic profiles of the aggregate sample and the two study subsamples. Section B contains survey results that detail acceptance/rejection of the five study hypotheses.

Section A: Demographic Profile

This section contains demographic data for the aggregate, and the two study subsamples, which were Subsample One (or MSWs) and Subsample Two (or MHSWs). Results obtained from frequency analysis are listed below for race, sex, age, degree, marital status, income status, training setting, and experience.

Race

As shown in Table 3.0a, of 87 aggregate survey respondents, 46 (or 53%) were Black, while 41 (or 47%) were white. Therefore, the aggregate survey respondent was Black.

Race by MSWs and MHSWs (Subsamples One and Two)

As shown in Table 3.1a, of 56 MSWs, 30 (or 54%) were Black, and 26 (or 46%) were white.

As shown in Table 3.1b, of 31 MHSWs, 16 (or 52%) were Black, while 15 (or 48%) were white. Therefore, the typical MSW and MHSW was Black.
<table>
<thead>
<tr>
<th>Demographic Profile Of Aggregate Sample: Race, Sex, Age, And Degree In Numbers (#), And Percents (%) (N=87)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Race</strong></td>
</tr>
<tr>
<td>Black</td>
</tr>
<tr>
<td>White</td>
</tr>
<tr>
<td>TOTALS</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>TOTALS</td>
</tr>
<tr>
<td><strong>Age</strong></td>
</tr>
<tr>
<td>&lt; 35</td>
</tr>
<tr>
<td>35 - 39</td>
</tr>
<tr>
<td>40 - 44</td>
</tr>
<tr>
<td>45 - 49</td>
</tr>
<tr>
<td>50 +</td>
</tr>
<tr>
<td>TOTALS</td>
</tr>
<tr>
<td><strong>Degree</strong></td>
</tr>
<tr>
<td>BA/BS</td>
</tr>
<tr>
<td>BSW</td>
</tr>
<tr>
<td>MA/MS</td>
</tr>
<tr>
<td>MSW</td>
</tr>
<tr>
<td>EdD/PhD</td>
</tr>
<tr>
<td>TOTALS</td>
</tr>
</tbody>
</table>
Table 3.0b  Demographic Profile Of Aggregate Sample: Marital Status, Income Status, Training Setting, And Experience In Numbers (#), And Percents (%) (N=87)

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>16</td>
<td>18.4</td>
</tr>
<tr>
<td>Married</td>
<td>36</td>
<td>41.4</td>
</tr>
<tr>
<td>Separated</td>
<td>6</td>
<td>6.9</td>
</tr>
<tr>
<td>Div/Wid.*</td>
<td>29</td>
<td>33.3</td>
</tr>
<tr>
<td>TOTALS</td>
<td>87</td>
<td>100.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Income Status</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 24,999</td>
<td>15</td>
<td>17.2</td>
</tr>
<tr>
<td>25,000 - 29,999</td>
<td>28</td>
<td>32.2</td>
</tr>
<tr>
<td>30,000 - 34,999</td>
<td>26</td>
<td>29.9</td>
</tr>
<tr>
<td>35,000 - 39,999</td>
<td>6</td>
<td>6.9</td>
</tr>
<tr>
<td>40,000 +</td>
<td>12</td>
<td>13.8</td>
</tr>
<tr>
<td>TOTALS</td>
<td>87</td>
<td>100.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Training Setting**</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pu.h.</td>
<td>31</td>
<td>36.0</td>
</tr>
<tr>
<td>Pr.h.</td>
<td>23</td>
<td>26.0</td>
</tr>
<tr>
<td>Cmhc.</td>
<td>18</td>
<td>21.0</td>
</tr>
<tr>
<td>Pu.mh.</td>
<td>13</td>
<td>15.0</td>
</tr>
<tr>
<td>Pr.mh.</td>
<td>2</td>
<td>2.0</td>
</tr>
<tr>
<td>TOTALS</td>
<td>87</td>
<td>100.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Experience</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 7 years</td>
<td>13</td>
<td>14.94</td>
</tr>
<tr>
<td>7 - 10 years</td>
<td>19</td>
<td>21.83</td>
</tr>
<tr>
<td>10 - 15 years</td>
<td>32</td>
<td>36.79</td>
</tr>
<tr>
<td>15 - 20 years</td>
<td>17</td>
<td>19.54</td>
</tr>
<tr>
<td>20 +</td>
<td>6</td>
<td>6.90</td>
</tr>
<tr>
<td>TOTALS</td>
<td>87</td>
<td>100.00</td>
</tr>
</tbody>
</table>

*Div/wid. = divorced or widowed.
**Pu.h. = public hospital; pu.mh. = public mental hospital; pr.h. = private hospital; pr.mh. = private mental hospital; cmhc. = community mental health center.
Table 3.1a  Demographic Profile Of Medical Social Workers (MSWs) Subsample: Race, Sex, Age, And Degree In Numbers (#), And Percents (%) (N=56)

<table>
<thead>
<tr>
<th></th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>30</td>
<td>54</td>
</tr>
<tr>
<td>White</td>
<td>26</td>
<td>46</td>
</tr>
<tr>
<td>TOTALS</td>
<td>56</td>
<td>100</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>42</td>
<td>75</td>
</tr>
<tr>
<td>Male</td>
<td>14</td>
<td>25</td>
</tr>
<tr>
<td>TOTALS</td>
<td>56</td>
<td>100</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 35</td>
<td>11</td>
<td>19.7</td>
</tr>
<tr>
<td>35 - 39</td>
<td>12</td>
<td>21.4</td>
</tr>
<tr>
<td>40 - 44</td>
<td>20</td>
<td>35.7</td>
</tr>
<tr>
<td>45 - 49</td>
<td>9</td>
<td>16.1</td>
</tr>
<tr>
<td>50 +</td>
<td>4</td>
<td>7.1</td>
</tr>
<tr>
<td>TOTALS</td>
<td>56</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Degree</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BA/BS</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>BSW</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>MA/MS</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MSW</td>
<td>50</td>
<td>89</td>
</tr>
<tr>
<td>EdD/PhD</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TOTALS</td>
<td>56</td>
<td>100</td>
</tr>
</tbody>
</table>
Table 3.1b Demographic Profile Of Mental Health Social Workers (MHSWs) Subsample: Race, Sex, Age, And Degree In Numbers (#), And Percents (%) (N=31)

<table>
<thead>
<tr>
<th></th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>16</td>
<td>52</td>
</tr>
<tr>
<td>White</td>
<td>15</td>
<td>48</td>
</tr>
<tr>
<td>TOTALS</td>
<td>31</td>
<td>100</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>21</td>
<td>68</td>
</tr>
<tr>
<td>Male</td>
<td>10</td>
<td>32</td>
</tr>
<tr>
<td>TOTALS</td>
<td>31</td>
<td>100</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 35</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>35 - 39</td>
<td>6</td>
<td>19</td>
</tr>
<tr>
<td>40 - 44</td>
<td>11</td>
<td>36</td>
</tr>
<tr>
<td>45 - 49</td>
<td>7</td>
<td>23</td>
</tr>
<tr>
<td>50 +</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>TOTALS</td>
<td>31</td>
<td>100</td>
</tr>
<tr>
<td><strong>Degree</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BA/BS</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>BSW</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MA/MS</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MSW</td>
<td>31</td>
<td>100</td>
</tr>
<tr>
<td>EdD/PhD</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TOTALS</td>
<td>31</td>
<td>100</td>
</tr>
</tbody>
</table>
Sex

As shown in Table 3.0a, of 87 aggregate survey respondents, 63 (or 72%) were female, and 24 (or 28%) were male. Therefore, the aggregate survey respondent was female.

Sex by MSWs and MHSWs (Subsamples One and Two)

As shown in Table 3.1a, of 56 MSWs, 42 (or 75%) were female, while 14 (or 25%) were male.

As shown in Table 3.1b, of 31 MHSWs, 21 (or 68%) were female, and 10 (or 32%) were male. Therefore, the typical MSW and MHSW was female.

Age

As shown in Table 3.0a, of 87 aggregate survey respondents, 15 (or 16) were under 35, 18 (or 21%) were 35-39, and 31 (or 36%) were 40-44. Meanwhile, 16 (or 18%) were 45-49, and seven (or 9%) were 50+. Therefore, the aggregate survey respondent was 40-44 years old.

Age by MSWs and MHSWs (Subsamples One and Two)

As shown in Table 3.1a, of 56 MSWs, 11 (or 19.7%) were under 35, 12 (or 21.4%) were 35-39, and 20 (or 35.7%) were 40-44. Also, nine (or 16.1%) were 45-49, and four (or 7.1%) were 50+.

As shown in Table 3.1b, of 31 MHSWs, four (or 12%) were under 35, six (or 19%) were 35-39, and 11 (or 36%) were 40-44. Also, seven (or 23%) were 45-49, and three (or 10%) were 50+. Therefore, the typical MSW and MHSW was 40-44 years old.
Degree

As shown in Table 3.0a, of 87 aggregate survey respondents, two (or 2.3%) had a BA/BS, four (or 4.6%) had a BSW, and none (or 0%) had a MA/MS. Also, 81 (or 93.1%) had a MSW, and none (or 0%) had an EdD/PhD. Therefore, the aggregate survey respondent had a MSW degree.

Degree by MSWs and MHSWs (Subsamples One and Two)

As shown in Table 3.1a, of 56 MSWs, two (or 4%) had a BA/BS, four (or 7%) had a BSW, and none (or 0%) had a MA/MS. Meanwhile, 50 (or 89%) had a MSW, and none (or 0%) had an EdD/PhD.

As shown in Table 3.1b, of 31 MHSWs, none (or 0%) had a BA/BS, none (or 0%) had a BSW, and none (or 0%) had a MA/MS. Meanwhile, 31 (or 100%) had a MSW, and none (or 0%) had an EdD/PhD. Therefore, the typical MSW and MHSW had a MSW degree.

Marital Status

As shown in Table 3.0b, of 87 aggregate survey respondents, 16 (or 18.4%) were single, and 36 (or 41.4%) were married. In addition, six (or 6.9%) were separated, and 29 (or 33.3%) were divorced or widowed. Therefore, the aggregate survey respondent was married.

Marital Status by MSWs and MHSWs (Subsamples One and Two)

As shown in Table 3.2a, of 56 MSWs, 12 (or 21%) were single, and 24 (or 43%) were married. Also, four (or 7%) were separated, and 16 (or 29%) were divorced or widowed.

As shown in Table 3.2b, of 31 MHSWs, four (or 13%) were
Table 3.2a  **Demographic Profile Of Medical Social Workers (MSWs) Subsample: Marital Status, Income Status, Training Setting, And Experience In Numbers (#), And Percents (%) (N=56)**

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>12</td>
<td>21.0</td>
</tr>
<tr>
<td>Married</td>
<td>24</td>
<td>43.0</td>
</tr>
<tr>
<td>Separated</td>
<td>4</td>
<td>7.0</td>
</tr>
<tr>
<td>Div/Wid.*</td>
<td>16</td>
<td>29.0</td>
</tr>
<tr>
<td>TOTALS</td>
<td>56</td>
<td>100.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Income Status</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 24,999</td>
<td>11</td>
<td>19.6</td>
</tr>
<tr>
<td>25,000 - 29,999</td>
<td>20</td>
<td>35.7</td>
</tr>
<tr>
<td>30,000 - 34,999</td>
<td>17</td>
<td>30.4</td>
</tr>
<tr>
<td>35,000 - 39,999</td>
<td>1</td>
<td>1.8</td>
</tr>
<tr>
<td>40,000 +</td>
<td>7</td>
<td>12.5</td>
</tr>
<tr>
<td>TOTALS</td>
<td>56</td>
<td>100.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Training Setting**</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pu.h.</td>
<td>21</td>
<td>37.5</td>
</tr>
<tr>
<td>Pr.h.</td>
<td>21</td>
<td>37.5</td>
</tr>
<tr>
<td>Cmhc.</td>
<td>10</td>
<td>18.0</td>
</tr>
<tr>
<td>Pu.mh.</td>
<td>4</td>
<td>7.0</td>
</tr>
<tr>
<td>Pr.mh.</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>TOTALS</td>
<td>56</td>
<td>100.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Experience</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 7 years</td>
<td>9</td>
<td>16.1</td>
</tr>
<tr>
<td>7 - 10 years</td>
<td>14</td>
<td>25.0</td>
</tr>
<tr>
<td>10 - 15 years</td>
<td>22</td>
<td>39.3</td>
</tr>
<tr>
<td>15 - 20 years</td>
<td>8</td>
<td>14.3</td>
</tr>
<tr>
<td>20 +</td>
<td>3</td>
<td>5.3</td>
</tr>
<tr>
<td>TOTALS</td>
<td>56</td>
<td>100.0</td>
</tr>
</tbody>
</table>

*Div/wid. = divorced or widowed.  
**Pu.h. = public hospital; pu.mh. = public mental hospital; pr.h. = private hospital; pr.mh. = private mental hospital; cmhc. = community mental health center.
<table>
<thead>
<tr>
<th>Table 3.2b</th>
<th>Demographic Profile Of Mental Health Social Workers (MHSWs) Subsample: Marital Status, Income Status, Training Setting, And Experience In Numbers (#), And Percents (%) (N=31)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Marital Status</strong></td>
<td>#</td>
</tr>
<tr>
<td>Single</td>
<td>4</td>
</tr>
<tr>
<td>Married</td>
<td>12</td>
</tr>
<tr>
<td>Separated</td>
<td>2</td>
</tr>
<tr>
<td>Div/Wid.*</td>
<td>13</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>31</td>
</tr>
<tr>
<td><strong>Income Status</strong></td>
<td>#</td>
</tr>
<tr>
<td>&lt; 24,999</td>
<td>4</td>
</tr>
<tr>
<td>25,000 - 29,999</td>
<td>8</td>
</tr>
<tr>
<td>30,000 - 34,999</td>
<td>9</td>
</tr>
<tr>
<td>35,000 - 39,999</td>
<td>5</td>
</tr>
<tr>
<td>40,000 +</td>
<td>5</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>31</td>
</tr>
<tr>
<td><strong>Training Setting</strong></td>
<td>#</td>
</tr>
<tr>
<td>Pu.h.</td>
<td>10</td>
</tr>
<tr>
<td>Pr.h.</td>
<td>2</td>
</tr>
<tr>
<td>Cmhc.</td>
<td>8</td>
</tr>
<tr>
<td>Pu.mh.</td>
<td>9</td>
</tr>
<tr>
<td>Pr.mh.</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>31</td>
</tr>
<tr>
<td><strong>Experience</strong></td>
<td>#</td>
</tr>
<tr>
<td>&lt; 7 years</td>
<td>4</td>
</tr>
<tr>
<td>7 - 10 years</td>
<td>5</td>
</tr>
<tr>
<td>10 - 15 years</td>
<td>10</td>
</tr>
<tr>
<td>15 - 20 years</td>
<td>9</td>
</tr>
<tr>
<td>20 +</td>
<td>3</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td>31</td>
</tr>
</tbody>
</table>

*Div/wid. = divorced or widowed.
**Pu.h. = public hospital; pu.mh. = public mental hospital; pr.h. = private hospital; pr.mh. = private mental hospital; cmhc. = community mental health center.
single, and 12 (or 39%) were married. Meanwhile, two (or 6%) were separated, and 13 (or 42%) were divorced or widowed. Therefore, the typical MSW was married, while the typical MHSW was divorced or widowed.

Income Status

As shown in Table 3.0b, of 87 aggregate survey respondents, 15 (or 17.2%) earned $24,999 or less, 28 (or 32.2%) earned $25,000—29,999, and 26 (or 29.9%) earned $30,000—34,999. In addition, six (or 6.9%) earned $35,000—39,999, and 12 (or 13.8%) earned $40,000 and above. Therefore, the aggregate survey respondent earned $25,000—29,999 dollars.

Income Status by MSWs and MHSWs (Subsamples One and Two)

As shown in Table 3.2a, of 56 MSWs, 11 (or 19.6%) earned $24,999 or less, 20 (or 35.7%) earned $25,000—29,999, and 17 (or 30.4%) earned $30,000—34,999. Also, one (or 1.8%) earned $35,000—39,999, and seven (or 12.5%) earned $40,000 and above.

As shown in Table 3.2b, of 31 MHSWs, four (or 13%) earned $24,999 or less, eight (or 26%) earned $25,000—29,999, and nine (or 29%) earned $30,000—34,999. Meanwhile, five (or 16%) earned $35,000—39,999, and five (or 16%) earned $40,000 and above. Therefore, the typical MSW earned $25,000—29,999 dollars, while the typical MHSW earned $30,000—34,999 dollars.
Training Setting

As shown in Table 3.0b, of 87 aggregate survey respondents, 31 (or 36%) were trained in a public hospital, 23 (or 26%) were trained in a private hospital, and 18 (or 21%) were trained in a community mental health center. Also, 13 (or 15%) were trained in a public mental hospital, and two (or 2%) were trained in a private mental hospital. Therefore, the aggregate survey respondent was trained in a public hospital.

Training by MSWs and MHSWs (Subsamples One and Two)

As shown in Table 3.2a, of 56 MSWs, 21 (or 37.5%) were trained in a public hospital, 21 (or 37.5%) were trained in a private hospital, and 10 (or 18%) were trained in a community mental health center. In addition, four (or 7%) were trained in a public mental hospital, and none (or 0%) were trained in a private mental hospital.

As shown in Table 3.2b, of 31 MHSWs, 10 (or 32%) were trained in a public hospital, two (or 6%) were trained in a private hospital, and eight (or 26%) were trained in a community mental health center. Meanwhile, nine (or 29%) were trained in a public mental hospital, and two (or 6%) were trained in a private mental hospital. Therefore, the typical MSW was likely to have received training in either a public or private hospital, while the typical MHSW was trained in a public hospital.
Experience

As shown in Table 3.0b, of 87 aggregate survey respondents, 13 (or 14.94%) had seven years or less experience in medical or mental health social work, 19 (or 21.83%) had 7-10 years of experience, and 32 (or 36.79%) had 10-15 years of experience. Also, 17 (or 19.54%) had 15-20 years of experience, and six (or 6.9%) had 20+ years of experience. Therefore, the aggregate survey respondent had 10-15 years of experience in either medical or mental health social work.

Experience by MSWs and MHSWs (Subsamples One and Two)

As shown in Table 3.2a, of 56 MSWs, nine (or 16.1%) had seven years or less experience in medical social work, 14 (or 25%) had 7-10 years of experience, and 22 (or 39.3%) had 10-15 years of experience. In addition, eight (or 14.3%) had 15-20 years of experience, and three (or 5.3%) had 20+ years of experience.

As shown in Table 3.2b, of 31 MHSWs, four (or 13%) had seven years or less experience in mental health social work, and five (or 16%) had 7-10 years of experience. Meanwhile, 10 (or 32%) had 10-15 years of experience, nine (or 29%) had 15-20 years of experience, and three (or 10%) had 20+ years of experience. Therefore, the typical MSW and MHSW had 10-15 years of experience in either medical or mental health social work.
Summary: Demographic Profile of the Aggregate Survey Respondent

In summary, the aggregate survey respondent was a Black married female, who was 40-44 years old, had a MSW degree, and received training in a public hospital. She earned $25,000-29,999 dollars annually, and had 10-15 years of experience in either medical or mental health social work.

Demographic Profile of the Typical MSW and MHSW (Subsamples One and Two)

In summary, the typical MSW was a Black married female, who was 40-44 years old, had a MSW degree, and was likely to have received training in either a public or private hospital. She earned $25,000-29,999 dollars annually, and had 10-15 years of experience in medical social work.

In summary, the typical MHSW was a Black divorced or widowed female, who was 40-44 years old, had a MSW degree, and received training in a public hospital. She earned $30,000-34,999 dollars annually, and had 10-15 years of experience in mental health social work.

Conclusion

When the aggregate survey respondent, typical MSW, and typical MHSW are compared, they appear to be identical in such areas as race, sex, age, degree, and years of experience.

However, the typical MSW was likely to have received training in a public or private hospital, whereas the
aggregate survey respondent and typical MHSW received training in a public hospital.

Moreover, the aggregate survey respondent and typical MSW earned $25,000–29,999 dollars annually, whereas the typical MHSW earned $30,000–34,999 dollars annually.

Section B: Survey Results

As previously mentioned, five dimensions in the survey were as follows: Authoritarianism, Benevolence, Mental Hygiene Ideology, Social Restrictiveness, and Interpersonal Etiology. These five dimensions were associated with the five study hypotheses.

Survey respondents could select from among four responses, for each of the 51 survey items. The four responses were (SD) strongly disagree, (D) disagree, (A) agree, and (SA) strongly agree. Survey respondents were instructed to select the one response that best reflected their opinion.

First, the most frequent responses were calculated for the two study subsamples, MSWs and MHSWs. Second, Pearson's r was then calculated and the level of significance was set at the .05 level to accept or reject the study hypotheses which compared the survey responses in each dimension. Results are detailed below.

Authoritarianism

Hypothesis one was related to the Authoritarianism dimension. This hypothesis stated that there was a statistically significant difference between the attitudes
of MSWs and MHSWs toward mental illness on the Authoritarianism factor as measured by the Opinions About Mental Illness Scale.

The Authoritarianism dimension consisted of 11 survey items. These items are listed below.

Item #

1. NERVOUS BREAKDOWNS USUALLY RESULT WHEN PEOPLE WORK TOO HARD.

6. IT IS EASY TO RECOGNIZE SOMEONE WHO ONCE HAD A SERIOUS MENTAL ILLNESS.

9. WHEN A PERSON HAS A PROBLEM OR A WORRY, IT IS BEST NOT TO THINK ABOUT IT, BUT KEEP BUSY WITH MORE PLEASANT THINGS.

11. THERE IS SOMETHING ABOUT MENTAL PATIENTS THAT MAKES IT EASY TO TELL THEM FROM 'NORMAL' PEOPLE.

16. PEOPLE WOULD NOT BECOME MENTALLY ILL IF THEY AVOIDED BAD THOUGHTS.

19. A HEART PATIENT HAS JUST ONE THING WRONG WITH HIM/HER WHILE A MENTALLY ILL PERSON IS COMPLETELY DIFFERENT FROM OTHER PATIENTS.

21. PEOPLE WITH MENTAL ILLNESS SHOULD NEVER BE TREATED IN THE SAME HOSPITAL AS PEOPLE WITH PHYSICAL ILLNESS.

39. MENTAL ILLNESS IS USUALLY CAUSED BY SOME DISEASE OF THE NERVOUS SYSTEM.

43. COLLEGE PROFESSORS ARE MORE LIKELY TO BECOME MENTALLY ILL THAN ARE BUSINESSMEN.
46. SOMETIMES MENTAL ILLNESS IS A PUNISHMENT FOR BAD DEEDS.

48. ONE OF THE MAIN CAUSES OF MENTAL ILLNESS IS A LACK OF MORAL STRENGTH OR WILLPOWER.

**Item #1**

When asked if nervous breakdowns usually resulted when people work too hard, of Subsample One (or MSWs), seven (or 12.5%) strongly disagreed, and 30 (or 53.6%) disagreed with this statement. Also, 17 (or 30.4%) agreed, while two (or 3.5%) strongly agreed with this statement (see Table 3.3a). Therefore, the majority (66%) of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with this statement.

Of Subsample Two (or MHSWs), six (or 19.3%) strongly disagreed, and 11 (or 35.5%) disagreed with this statement. In addition, 12 (or 8.7%) agreed, and two (6.5%) strongly agreed with this statement (see Table 3.3a). Therefore, the majority (54.8%) of Subsample One (or MHSWs) survey respondents strongly disagreed or disagreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents disagreed with this item.

**Item #6**

In response to the statement that it was easy to recognize someone who once had a serious mental illness, of Subsample One (or MSWs), 12 (or 21.4%) strongly disagreed, and 30 (or 53.6%) disagreed with this statement. Meanwhile,
Table 3.3a  Responses On The Authoritarianism Dimension For Subsample One (MSWs) And Subsample Two (MHSWs) In Numbers (#), And Percents (%) (N=87)

<table>
<thead>
<tr>
<th>SUBSAMPLES</th>
<th>One (MSWs)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SD</td>
</tr>
<tr>
<td></td>
<td>#</td>
</tr>
<tr>
<td>Item</td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>7</td>
</tr>
<tr>
<td>6.</td>
<td>12</td>
</tr>
<tr>
<td>9.</td>
<td>11</td>
</tr>
<tr>
<td>11.</td>
<td>12</td>
</tr>
<tr>
<td>16.</td>
<td>17</td>
</tr>
<tr>
<td>19.</td>
<td>9</td>
</tr>
<tr>
<td>21.</td>
<td>12</td>
</tr>
<tr>
<td>39.</td>
<td>12</td>
</tr>
<tr>
<td>43.</td>
<td>8</td>
</tr>
<tr>
<td>46.</td>
<td>29</td>
</tr>
<tr>
<td>48.</td>
<td>22</td>
</tr>
</tbody>
</table>
Table 3.3a  (Continued)

SUBSAMPLES

Two (MHSWs)

<table>
<thead>
<tr>
<th>Item</th>
<th>SD</th>
<th></th>
<th>D</th>
<th></th>
<th>A</th>
<th></th>
<th>SA</th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>6</td>
<td>19.3</td>
<td>11</td>
<td>35.5</td>
<td>12</td>
<td>38.7</td>
<td>2</td>
<td>6.5</td>
<td>31</td>
</tr>
<tr>
<td>6.</td>
<td>7</td>
<td>22.6</td>
<td>15</td>
<td>48.4</td>
<td>8</td>
<td>25.8</td>
<td>1</td>
<td>3.2</td>
<td>31</td>
</tr>
<tr>
<td>9.</td>
<td>5</td>
<td>16.1</td>
<td>20</td>
<td>64.5</td>
<td>4</td>
<td>12.9</td>
<td>2</td>
<td>6.5</td>
<td>31</td>
</tr>
<tr>
<td>11.</td>
<td>3</td>
<td>9.7</td>
<td>21</td>
<td>67.7</td>
<td>4</td>
<td>12.9</td>
<td>3</td>
<td>9.7</td>
<td>31</td>
</tr>
<tr>
<td>16.</td>
<td>13</td>
<td>41.9</td>
<td>14</td>
<td>45.2</td>
<td>3</td>
<td>9.7</td>
<td>1</td>
<td>3.2</td>
<td>31</td>
</tr>
<tr>
<td>19.</td>
<td>7</td>
<td>22.6</td>
<td>17</td>
<td>54.8</td>
<td>2</td>
<td>6.5</td>
<td>5</td>
<td>16.1</td>
<td>31</td>
</tr>
<tr>
<td>21.</td>
<td>10</td>
<td>32.3</td>
<td>19</td>
<td>61.3</td>
<td>2</td>
<td>6.4</td>
<td>0</td>
<td>0.0</td>
<td>31</td>
</tr>
<tr>
<td>39.</td>
<td>2</td>
<td>6.5</td>
<td>11</td>
<td>35.5</td>
<td>12</td>
<td>38.7</td>
<td>6</td>
<td>19.3</td>
<td>31</td>
</tr>
<tr>
<td>43.</td>
<td>3</td>
<td>9.7</td>
<td>19</td>
<td>61.3</td>
<td>8</td>
<td>25.8</td>
<td>1</td>
<td>3.2</td>
<td>31</td>
</tr>
<tr>
<td>46.</td>
<td>11</td>
<td>35.4</td>
<td>10</td>
<td>32.3</td>
<td>10</td>
<td>32.3</td>
<td>0</td>
<td>0.0</td>
<td>31</td>
</tr>
<tr>
<td>48.</td>
<td>10</td>
<td>32.3</td>
<td>20</td>
<td>64.5</td>
<td>1</td>
<td>64.5</td>
<td>1</td>
<td>3.2</td>
<td>31</td>
</tr>
</tbody>
</table>
13 (or 23.2%) agreed, and one (or 1.8%) strongly agreed with this statement (see Table 3.3a). Therefore, the majority (75%) of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with this statement.

Of Subsample Two (or MHSWs), seven (or 22.6%) strongly disagreed, and 15 (or 48.4%) disagreed with this statement. Also, eight (or 25.8%) agreed and one (or 3.2%) strongly agreed with this statement (see Table 3.3a). Therefore, the majority (71%) of Subsample Two (or MHSWs) survey respondents strongly disagreed or disagreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents disagreed with this item.

**Item #9**

In response to the statement that when a person had a problem or a worry, it was best not to think about it, but keep busy with more pleasant things, of Subsample One (or MSWs), 11 (or 19.6%) strongly disagreed, and 33 (or 58.9%) disagreed with this statement. Also, 11 (or 19.6) agreed, while one (or 1.9%) strongly agreed with this statement (see Table 3.3a). Therefore, the majority (78.5%) of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with this statement.

Of Subsample Two (or MHSWs), five (or 16.1%) strongly disagreed, and 20 (or 64.5%) disagreed with this statement. In addition, four (or 12.9%) agreed, while two (or 6.5%) strongly agreed with this statement (see Table 3.3a).
Therefore, the majority (80.6%) of Subsample Two (or MHSWs) survey respondents strongly disagreed or disagreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents disagreed with this item.

**Item #11**

When questioned if there was something about mental patients that made it easy to tell them from 'normal' people, of Subsample One (or MSWs), 12 (or 21.4%) strongly disagreed, and 34 (or 60.7%) disagreed with this statement. Meanwhile, nine (or 16.1%) agreed, and one (or 1.8%) strongly agreed with this statement (see Table 3.3a). Therefore, the majority (82.1%) of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with this statement.

Of Subsample Two (or MHSWs), three (or 9.7%) strongly disagreed, and 21 (or 67.7%) disagreed with this statement. Also, four (or 12.9%) agreed, and three (or 9.7%) strongly agreed with this statement (see Table 3.3a). Therefore, the majority (77.4%) of Subsample Two (or MHSWs) survey respondents strongly disagreed or disagreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents disagreed with this item.

**Item #16**

When asked if people would not become mentally ill if they avoided bad thoughts, of Subsample One (or MSWs), 17
strongly disagreed, and 30 (or 53.6%) disagreed with this statement. In addition, eight (or 14.3%) agreed and one (or 1.7%) strongly agreed with this statement (see Table 3.3a). Therefore, the majority (84%) of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with this statement.

Of Subsample Two (or MHSWs), 13 (or 41.9%) strongly disagreed, while 17 (or 45.2%) disagreed with this statement. Also, three (or 9.7%) agreed, and one (or 3.2%) strongly agreed with this statement (see Table 3.3a). Therefore, the majority (87.1%) of Subsample Two (or MHSWs) survey respondents strongly disagreed or disagreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents disagreed with this item.

**Item #19**

In response to the statement that a heart patient had just one thing wrong with him/her, while a mentally ill person was completely different from other patients, of Subsample One (or MSWs), nine (or 16.1%) strongly disagreed, and 36 (or 64.3%) disagreed with this statement. In addition, 11 (or 19.6%) agreed, while none (or 0%) strongly agreed with this statement (see Table 3.3a). Therefore, the majority (80.4%) of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with this statement.
Of Subsample Two (or MHSWs), seven (or 22.6%) strongly disagreed, and 17 (or 54.8%) disagreed with this statement. Meanwhile, two (or 6.5%) agreed, and five (16.1%) strongly agreed with this statement (see Table 3.3a). Therefore, the majority (77.4%) of Subsample Two (or MHSWs) survey respondents strongly disagreed or disagreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents disagreed with this item.

**Item #21**

When questioned if people with mental illness should never be treated in the same hospital as people with physical illness, of Subsample One (or MSWs), 12 (or 21.4%) strongly disagreed, and 36 (or 64.3%) disagreed with this statement. Also, eight (or 14.3%) agreed, and none (or 0%) strongly agreed with this statement (see Table 3.3a). Therefore, the majority (85.7%) of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with statement.

Of Subsample Two (or MHSWs), 10 (or 32.3%) strongly disagreed, while 19 (or 61.3%) disagreed with this statement. Meanwhile, two (or 6.4%) agreed, and none (or 0%) strongly agreed with this statement (see Table 3.3a). Therefore, the majority (93.6%) of Subsample Two (or MHSWs) survey respondents strongly disagreed or disagreed with this statement. Consequently, the majority of Subsamples One and
Two (or MSWs and MHSWs) survey respondents disagreed with this item.

Item #39

In response to the statement that mental illness was usually caused by some disease of the nervous system, of Subsample One (or MSWs), 12 (or 21.4%) strongly disagreed, while 23 (or 41.1%) disagreed with this statement. In addition, 12 (or 21.4%) agreed, and nine (or 16.1%) strongly agreed with this statement (see Table 3.3a). Therefore, the majority (62.5%) of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with this statement.

Of Subsample Two (or MHSWs), two (or 6.5%) strongly disagreed, and 11 (or 35.5%) disagreed with this statement. Also, 12 (or 38.7%) agreed, while six (or 19.3%) strongly agreed with this statement (see Table 3.3a). Therefore, the majority (58%) of Subsample Two (or MHSWs) survey respondents strongly agreed or agreed with this statement. Consequently, the majority of Subsample One (or MSWs) survey respondents disagreed with this item, while the majority of Subsample Two (or MHSWs) survey respondents agreed with this item.

Item #43

When asked if college professors were more likely to become mentally ill than were businessmen, of Subsample One (or MSWs), eight (or 16.1%) strongly disagreed, and 29 (or 51.9%) disagreed with this statement. Also, 16 (or 28.5%)
agreed, while two (or 3.5%) strongly agreed with this statement (see Table 3.3a). Therefore, the majority (68%) of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with this statement.

Of Subsample Two (or MHSWs), three (or 9.7%) strongly disagreed, while 19 (or 61.3%) disagreed with this statement. In addition, eight (or 25.8%) agreed, and one (or 3.2%) strongly agreed with this statement (see Table 3.3a). Therefore, the majority (71%) of Subsample Two (or MHSWs) survey respondents strongly disagreed or disagreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents disagreed with this item.

Item #46

When questioned if sometimes mental illness was a punishment for bad deeds, of Subsample One (or MSWs), 29 (or 51.8%) strongly disagreed, and 16 (or 28.5%) disagreed with this statement. Meanwhile, 10 (or 17.9%) agreed, and one (or 1.8%) strongly agreed with this statement (see Table 3.3a). Therefore, the majority (80.3%) of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with this statement.

Of Subsample Two (or MHSWs), 11 (or 35.4%) strongly disagreed, while 10 (or 32.3%) disagreed with this statement. Also, 21 (or 32.3%) agreed, and none (or 0%) strongly agreed with this statement (see Table 3.3a).
Therefore, the majority (67.7%) of Subsample Two (or MHSWs) strongly disagreed or disagreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents disagreed with this item.

**Item #48**

In response to the statement that one of the main causes of mental illness was a lack of moral strength or willpower, of Subsample One (or MSWs), 22 (or 39.3%) strongly disagreed, and 32 (or 57.1%) disagreed with this statement. Also, two (or 3.6%) agreed, while none (or 0%) strongly agreed with this statement (see Table 3.3a). Therefore, the majority (96.4%) of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with this statement.

Of Subsample Two (or MHSWs), 10 (or 32.3%) strongly disagreed, while 20 (or 64.5%) disagreed with this statement. In addition, one (or 3.2%) agreed, and none (or 0%) strongly agreed with this statement (see Table 3.3a). Therefore, the majority (96.8%) of Subsample Two (or MHSWs) strongly disagreed or disagreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents disagreed with this item.

Of the 11 items in the Authoritarianism dimension, Subsamples One and Two (or MSWs and MHSWs) aggregate responses appeared to be the same in 10 out of 11 items. When means were examined, the means for Subsample One (or MSWs) and Subsample Two (or MHSWs) were 112.273 and 66.727,
the variances were 128.018 and 108.818, and standard
deviations were 11.315 and 10.432 respectively (see Table
3.3b).

When the Pearson r was calculated, the r value was
.433, indicating that there was a relatively weak
relationship between occupation and the Authoritarianism
dimension (see Table 3.3b). In addition, differences did
not reach the .05 level of significance (p = .363, df = 9)
(see Table 3.3b).

Therefore, Hypothesis One which stated that there was a
statistically significant difference between the attitudes
of MSWs and MHSWs toward mental illness on the
Authoritarianism factor as measured by the Opinions About
Mental Illness Scale was rejected.

Benevolence

Hypothesis two was related to the Benevolence
dimension. This hypothesis stated that there was a
statistically significant difference between the attitudes
of MSWs and MHSWs toward mental illness on the Benevolence
factor as measured by the Opinions About Mental Illness
Scale.

The Benevolence dimension included 14 survey items.
These items are listed below.

Item #

2. MENTAL ILLNESS IS AN ILLNESS LIKE ANY OTHER.
12. EVEN THOUGH PATIENTS IN MENTAL HOSPITALS
   BEHAVE IN FUNNY WAYS, IT IS WRONG TO LAUGH AT
   THEM.
Table 3.3b  
Report Of Means (X), Standard Deviations (s), Variances (s²), Probability (p), And Pearson's r (r) From The Authoritarianism Dimension For Subsample One (MSWs) And Subsample Two (MHSWs) (N=87)

<table>
<thead>
<tr>
<th>Subsample One</th>
<th>Subsample Two</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MSWs</td>
</tr>
<tr>
<td>x</td>
<td>112.273</td>
</tr>
<tr>
<td>s</td>
<td>11.315</td>
</tr>
<tr>
<td>s²</td>
<td>128.018</td>
</tr>
<tr>
<td></td>
<td>MHSWs</td>
</tr>
<tr>
<td>x</td>
<td>66.727</td>
</tr>
<tr>
<td>s</td>
<td>10.432</td>
</tr>
<tr>
<td>s²</td>
<td>108.818</td>
</tr>
</tbody>
</table>

* probability = .363
r = .433
degrees of freedom = 9

* p < .05

17. PATIENTS IN MENTAL HOSPITALS ARE IN MANY WAYS LIKE CHILDREN.
18. MORE TAX MONEY SHOULD BE SPENT IN THE CARE AND TREATMENT OF PEOPLE WITH SEVERE MENTAL ILLNESS.
22. ANYONE WHO TRIES HARD TO BETTER HIM/HERSELF DESERVES THE RESPECT OF OTHERS.
26. PEOPLE WHO HAVE BEEN PATIENTS IN A MENTAL HOSPITAL WILL NEVER BE THEMSELVES AGAIN.
27. MANY MENTAL PATIENTS ARE CAPABLE OF SKILLED LABOR, EVEN THOUGH IN SOME WAYS THEY ARE VERY DISTURBED MENTALLY.
32. TO BECOME A PATIENT IN A MENTAL HOSPITAL IS TO BECOME A FAILURE IN LIFE.

34. IF A PATIENT IN A MENTAL HOSPITAL ATTACKS SOMEONE, S/HE SHOULD BE PUNISHED SO S/HE DOES NOT DO IT AGAIN.

36. EVERY MENTAL HOSPITAL SHOULD BE SURROUNDED BY A HIGH FENCE AND GUARDS.

37. THE LAW SHOULD ALLOW A WOMAN TO DIVORCE HER HUSBAND AS SOON AS HE HAS BEEN CONFINED IN A MENTAL HOSPITAL WITH A SEVERE MENTAL ILLNESS.

40. REGARDLESS OF HOW YOU LOOK AT IT, PATIENTS WITH SEVERE MENTAL ILLNESS ARE NO LONGER REALLY HUMAN.

47. OUR MENTAL HOSPITALS SHOULD BE ORGANIZED IN A WAY THAT MAKES THE PATIENT FEEL AS MUCH AS POSSIBLE LIKE S/HE IS LIVING AT HOME.

49. THERE IS LITTLE THAT CAN BE DONE FOR PATIENTS IN A MENTAL HOSPITAL EXCEPT TO SEE THAT THEY ARE COMFORTABLE AND WELL FED.

Item #2

When asked if mental illness was an illness like any other, of Subsample One (or MSWs), three (or 5.4%) strongly disagreed, while 18 (or 32.1%) disagreed with this statement. Also, 28 (or 50%) agreed, and seven (or 12.5%) strongly agreed with this statement (see Table 3.4a).

Therefore, the majority (62.5%) of Subsample One (or MSWs)
survey respondents strongly agreed or agreed with this statement.

Of Subsample One (or MHSWs), two (or 7%) strongly disagreed, and 10 (or 32%) disagreed with this statement. Meanwhile, 15 (or 49%) agreed, and four (or 12%) strongly agreed with this statement (see Table 3.4a). Therefore, the majority (51%) of Subsample Two (or MHSWs) survey respondents strongly agreed or agreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents agreed with this item.

Item #12

In response to the statement that even though patients in mental hospitals behaved in funny ways, it was wrong to laugh at them, of Subsample One (or MSWs), five (or 9%) strongly disagreed, and 19 (or 33%) disagreed with this statement. In addition, 22 (or 39%) agreed, while 10 (or 19%) strongly agreed with this statement (see Table 3.4a). Therefore, the majority (58%) of Subsample One (or MSWs) survey respondents strongly agreed or agreed with this statement.

Of Subsample Two (or MHSWs), four (or 13%) strongly disagreed, while nine (or 29%) disagreed with this statement. Also, nine (or 29%) agreed, and nine (or 29%) strongly agreed with this statement (see Table 3.4a). Therefore, the majority (58%) of Subsample Two (or MHSWs)
Table 3.4a  Responses On The Benevolence Dimension For Subsample One (MSWs) And Subsample Two (MHSWs) In Numbers (#), And Percents (%) (N=87)

<table>
<thead>
<tr>
<th>Item</th>
<th>SD</th>
<th>5.4</th>
<th>3</th>
<th>D</th>
<th>32.1</th>
<th>18</th>
<th>A</th>
<th>50.0</th>
<th>28</th>
<th>SA</th>
<th>12.5</th>
<th>7</th>
<th>Total</th>
<th>56</th>
<th>100</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>3</td>
<td>5.4</td>
<td>18</td>
<td>32.1</td>
<td>18</td>
<td>32.1</td>
<td>28</td>
<td>50.0</td>
<td>28</td>
<td>50.0</td>
<td>7</td>
<td>12.5</td>
<td>56</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>5</td>
<td>9.0</td>
<td>19</td>
<td>33.0</td>
<td>22</td>
<td>39.0</td>
<td>10</td>
<td>19.0</td>
<td>56</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>8</td>
<td>8.9</td>
<td>19</td>
<td>33.0</td>
<td>22</td>
<td>39.3</td>
<td>10</td>
<td>17.9</td>
<td>56</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>8</td>
<td>8.9</td>
<td>19</td>
<td>33.0</td>
<td>22</td>
<td>39.3</td>
<td>10</td>
<td>17.9</td>
<td>56</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>3</td>
<td>5.4</td>
<td>10</td>
<td>17.9</td>
<td>30</td>
<td>53.6</td>
<td>13</td>
<td>23.1</td>
<td>56</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>4</td>
<td>5.4</td>
<td>10</td>
<td>17.9</td>
<td>30</td>
<td>53.6</td>
<td>13</td>
<td>23.1</td>
<td>56</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>3</td>
<td>5.4</td>
<td>14</td>
<td>25.0</td>
<td>36</td>
<td>64.3</td>
<td>3</td>
<td>5.3</td>
<td>56</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32.</td>
<td>26</td>
<td>46.4</td>
<td>30</td>
<td>53.6</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>56</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34.</td>
<td>5</td>
<td>8.9</td>
<td>13</td>
<td>23.2</td>
<td>29</td>
<td>51.8</td>
<td>9</td>
<td>16.1</td>
<td>56</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36.</td>
<td>9</td>
<td>8.9</td>
<td>13</td>
<td>23.2</td>
<td>29</td>
<td>51.8</td>
<td>9</td>
<td>16.1</td>
<td>56</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37.</td>
<td>14</td>
<td>25.0</td>
<td>39</td>
<td>69.6</td>
<td>3</td>
<td>5.4</td>
<td>0</td>
<td>0.0</td>
<td>56</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40.</td>
<td>28</td>
<td>50.0</td>
<td>27</td>
<td>48.2</td>
<td>1</td>
<td>1.8</td>
<td>0</td>
<td>0.0</td>
<td>56</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>47.</td>
<td>1</td>
<td>1.8</td>
<td>10</td>
<td>17.9</td>
<td>38</td>
<td>67.8</td>
<td>7</td>
<td>12.5</td>
<td>56</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>49.</td>
<td>18</td>
<td>32.1</td>
<td>16</td>
<td>28.6</td>
<td>22</td>
<td>39.3</td>
<td>0</td>
<td>0.0</td>
<td>56</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 3.4a  (Continued)

SUBSAMPLES

Two (MHSWs)

<table>
<thead>
<tr>
<th>Item</th>
<th>SD</th>
<th>D</th>
<th>A</th>
<th>SA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>2</td>
<td>7.0</td>
<td>10</td>
<td>32.0</td>
<td>4</td>
</tr>
<tr>
<td>12.</td>
<td>4</td>
<td>13.0</td>
<td>9</td>
<td>29.0</td>
<td>9</td>
</tr>
<tr>
<td>17.</td>
<td>4</td>
<td>13.0</td>
<td>8</td>
<td>26.0</td>
<td>9</td>
</tr>
<tr>
<td>18.</td>
<td>4</td>
<td>13.0</td>
<td>9</td>
<td>29.0</td>
<td>9</td>
</tr>
<tr>
<td>22.</td>
<td>1</td>
<td>3.2</td>
<td>4</td>
<td>12.9</td>
<td>15</td>
</tr>
<tr>
<td>26.</td>
<td>1</td>
<td>3.2</td>
<td>14</td>
<td>45.2</td>
<td>8</td>
</tr>
<tr>
<td>27.</td>
<td>3</td>
<td>9.7</td>
<td>5</td>
<td>16.1</td>
<td>19</td>
</tr>
<tr>
<td>32.</td>
<td>12</td>
<td>38.7</td>
<td>19</td>
<td>61.3</td>
<td>0</td>
</tr>
<tr>
<td>34.</td>
<td>4</td>
<td>12.9</td>
<td>10</td>
<td>32.3</td>
<td>7</td>
</tr>
<tr>
<td>36.</td>
<td>9</td>
<td>29.0</td>
<td>22</td>
<td>71.0</td>
<td>0</td>
</tr>
<tr>
<td>37.</td>
<td>3</td>
<td>9.7</td>
<td>11</td>
<td>35.5</td>
<td>11</td>
</tr>
<tr>
<td>40.</td>
<td>13</td>
<td>41.9</td>
<td>18</td>
<td>58.1</td>
<td>0</td>
</tr>
<tr>
<td>47.</td>
<td>1</td>
<td>3.2</td>
<td>6</td>
<td>19.4</td>
<td>21</td>
</tr>
<tr>
<td>49.</td>
<td>7</td>
<td>22.6</td>
<td>18</td>
<td>58.0</td>
<td>6</td>
</tr>
</tbody>
</table>
survey respondents strongly agreed or agreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents agreed with this item.

Item #17

When questioned if patients in mental hospitals were in many ways like children, of Subsample One (or MSWs), five (or 8.9%) strongly disagreed, and 19 (or 33.9%) disagreed with this statement. Meanwhile, 22 (or 39.3%) agreed, and 10 (or 17.9%) strongly agreed with this statement (see Table 3.4a). Therefore, the majority (57.2%) of Subsample One (or MSWs) survey respondents strongly agreed or agreed with this statement.

Of Subsample Two (or MHSWs), four (or 13%) strongly disagreed, while eight (or 26%) disagreed with this statement. Also, nine (or 29%) agreed, and 10 (or 32%) strongly agreed with this statement (see Table 3.4a). Therefore, the majority (61%) of Subsample Two (or MHSWs) survey respondents strongly agreed or agreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents agreed with this item.

Item #18

In response to the statement that more tax money should be spent in the care and treatment of people with severe mental illness, of Subsample One (or MSWs), eight (or 20%) strongly disagreed, and 12 (or 21%) disagreed with this
statement. In addition, 19 (or 34%) agreed, while 18 (or 25%) strongly agreed with this statement (see Table 3.4a). Therefore, the majority (59%) of Subsample One (or MSWs) survey respondents strongly agreed with this statement.

Of Subsample Two (or MHSWs), four (or 13%) strongly disagreed, while nine (or 29%) disagreed with this statement. Also, nine (or 29%) agreed, and nine (or 29%) strongly agreed with this statement (see Table 3.4a). Therefore, the majority (58%) of Subsample Two (or MHSWs) survey respondents strongly agreed or agreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents agreed with this item.

Item #22

When asked if anyone who tried hard to better him/herself deserved the respect of others, of Subsample One (or MSWs), three (or 5.4%) strongly disagreed, and 10 (or 17.9%) disagreed with this statement. Also, 30 (or 53.6%) agreed, while 13 (or 23.1%) strongly agreed with this statement (see Table 3.4a). Therefore, the majority (76.7%) of Subsample Two (or MSWs) survey respondents strongly agreed or agreed with this statement.

Of Subsample Two (or MHSWs), one (or 3.2%) strongly disagreed, while four (or 12.9%) disagreed with this statement. In addition, 15 (or 48.4%) agreed, and 11 (or 35.5%) strongly agreed with this statement (see Table 3.4a). Therefore, the majority (83.9%) of Subsample Two (or MHSWs)
strongly agreed or agreed with this statement.
Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents agreed with this item.

Item #26

In response to the statement that people who have been patients in a mental hospital will never be themselves again, of Subsample One (or MSWs), four (or 8.9%) strongly disagreed, while 33 (or 58.9%) disagreed with this statement. Also, 14 (or 25%) agreed, and five (or 7.2%) strongly agreed with this statement (see Table 3.4a). Therefore, the majority (67.8%) of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with this statement.

Of Subsample Two (or MHSWs), one (or 3.2%) strongly disagreed, and 14 (or 45.2%) disagreed with this statement. In addition, eight (or 25.8%) agreed, while eight (or 25.8%) strongly agreed with this statement (see Table 3.4a). Therefore, the majority (51.6%) of Subsample Two (or MHSWs) survey respondents strongly agreed or agreed with this statement. Consequently, the majority of Subsample One (or MSWs) survey respondents disagreed with this item, while the majority of Subsample Two (or MHSWs) survey respondents agreed with this item.

Item #27

When questioned if many mental patients were capable of skilled labor, even though in some ways they were very disturbed mentally, of Subsample One (or MSWs), three (or
5.4%) strongly disagreed, and 14 (or 25%) disagreed with this statement. Also, 36 (or 64.3%) agreed, while three (or 5.3%) strongly agreed with this statement (see Table 3.4a). Therefore, the majority (69.6%) of Subsample One (or MSWs) survey respondents strongly agreed or agreed with this statement.

Of Subsample Two (or MHSWs), three (or 9.7%) strongly disagreed, while five (or 16.1%) disagreed with this statement. In addition, 19 (or 61.3%) agreed, and four (or 12.9%) strongly agreed with this statement (see Table 3.4a). Therefore, the majority (74.2%) of Subsample Two (or MHSWs) survey respondents strongly agreed or agreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents agreed with this item.

**Item #32**

When asked if to become a patient in a mental hospital was to become a failure in life, of Subsample One (or MSWs), 26 (or 46.4%) strongly disagreed, while 30 (or 53.6%) disagreed with this statement. Also, none (or 0%) agreed, and none (0%) strongly agreed with this statement (see Table 3.4a). Therefore, the majority (100%) of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with this statement.

Of Subsample Two (or MHSWs), 12 (or 38.7%) strongly disagreed, and 19 (or 61.3%) disagreed with this statement. Meanwhile, none (or 0%) strongly agreed or agreed with this
statement (see Table 3.4a). Therefore, the majority (100%) of Subsample Two (or MHSWs) survey respondents strongly disagreed or disagreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents disagreed with this item.

Item #34

When questioned if a patient in a mental hospital attacked someone, s/he should be punished so s/he does not do it again, of Subsample One (or MSWs), five (or 8.9%) strongly disagreed, and 13 (or 23.2%) disagreed with this statement. Also, 29 (or 51.8%) agreed, while nine (or 16.1%) strongly agreed with this statement (see Table 3.4a). Therefore, the majority (67.9%) of Subsample One (or MSWs) survey respondents strongly agreed or agreed with this statement.

Of Subsample Two (or MHSWs), four (or 12.9%) strongly disagreed, while 10 (32.3%) disagreed with this statement. In addition, seven (or 22.6%) agreed, and 10 (32.2 %) strongly agreed with this statement (see Table 3.4a). Therefore, the majority (64.8%) of Subsample Two (or MHSWs) survey respondents strongly agreed or agreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents agreed with this item.

Item #36

In response to the statement that every mental hospital should be surrounded by a high fence and guards, of
Subsample One (or MSWs), 14 (or 25%) strongly disagreed and 39 (or 69.6%) disagreed with this statement. Meanwhile, three (or 5.4%) agreed, and none (or 0%) strongly agreed with this statement (see Table 3.4a). Therefore, the majority (94.6%) of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with this statement.

Of Subsample Two (or MHSWs), nine (or 29%) strongly disagreed, and 22 (or 71%) disagreed with this statement. In addition, none (or 0%) agreed, and none (or 0%) strongly agreed with this statement (see Table 3.4a). Therefore, the majority (100%) of Subsample Two (or MHSWs) survey respondents strongly disagreed or disagreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents disagreed with this item.

Item #37

When asked if the law should allow a woman to divorce her husband as soon as he has been confined in a mental hospital with a severe mental illness, of Subsample One (or MSWs), nine (or 16.1%) strongly disagreed, while 23 (or 41.1%) disagreed with this statement. Also, 20 (or 35.7%) agreed, and four (or 7.1%) strongly agreed with this statement (see Table 3.4a). Therefore, the majority (57.2%) of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with this statement.
Of Subsample Two (or MHSWs), three (or 9.7%) strongly disagreed, and 11 (or 35.5%) disagreed with this statement. In addition, 11 (or 35.5%) agreed, while six (or 19.3%) strongly agreed with this statement (see Table 3.4a). Therefore, the majority (54.8%) of Subsample Two (or MHSWs) survey respondents strongly agreed or agreed with this statement. Consequently, the majority of Subsample One (or MSWs) survey respondents disagreed with this item, while the majority of Subsample Two (or MHSWs) survey respondents agreed with this item.

Item #40

In response to the statement that regardless of how you looked at it, patients with severe mental illness were no longer really human, of Subsample One (or MSWs), 28 (or 50%) strongly disagreed, and 27 (or 48.2%) disagreed with this statement. Meanwhile, one (or 1.8%) agreed, and none (or 0%) strongly agreed with this statement (see Table 3.4a). Therefore, the majority (98.2%) of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with this statement.

Of Subsample Two (or MHSWs), 13 (or 41.9%) strongly disagreed, while 18 (or 58.1%) disagreed with this statement. Also, none (or 0%) agreed, and none (or 0%) strongly agreed with this statement (see Table 3.4a). Therefore, the majority (100%) of Subsample Two (or MHSWs) survey respondents strongly disagreed or disagreed with this statement. Consequently, the majority of Subsamples One and
Two (or MSWs and MHSWs) survey respondents disagreed with this item.

Item #47

When questioned if our mental hospitals should be organized in a way that made the patient feel as much as possible like s/he was living at home, of Subsample One (or MSWs), one (or 1.8%) strongly disagreed, and 10 (or 17.9%) disagreed with this statement. In addition, 38 (or 67.8%) agreed, and seven (or 12.5%) strongly agreed with this statement (see Table 3.4a). Therefore, the majority (80.3%) of Subsample One (or MSWs) survey respondents strongly agreed or agreed with this statement.

Of Subsample Two (or MHSWs), one (or 3.2%) strongly disagreed, and six (or 19.4%) disagreed with this statement. Meanwhile, 21 (or 67.8%) agreed, and three (or 9.6%) strongly agreed with this statement. Therefore, the majority (77.4%) of Subsample Two (or MHSWs) survey respondents strongly agreed or agreed with this statement (see Table 3.4a). Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents agreed with this item.

Item #49

In response to the statement that there was little that can be done for patients in a mental hospital except to see that they were comfortable and well fed, of Subsample One (or MSWs), 18 (or 32.1%) strongly disagreed, while 16 (or 28.6%) disagreed with this statement. Also, 22 (or 39.3%)
agreed, and none (or 0%) strongly agreed with this statement (see Table 3.4a). Therefore, the majority (60.7%) of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with this statement.

Of Subsample Two (or MHSWs), seven (or 22.6%) strongly disagreed, and 18 (or 58%) disagreed with this statement. In addition, six (or 19.4%) agreed, and none (or 0%) strongly agreed with this statement (see Table 3.4a). Therefore, the majority (80.6%) of Subsample Two (or MHSWs) survey respondents strongly disagreed or disagreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents disagreed with this item.

Of the 14 items in the Benevolence dimension, Subsamples One and Two (or MSWs and MHSWs) aggregate responses appeared to be the same in 12 out of 14 items. When means were examined, the means for Subsample One (or MSWs) and Subsample Two (or MHSWs) were 132.071 and 76.929, the variances were 980.994 and 261.918, and standard deviations were 31.321 and 16.184 respectively (see Table 3.4b).

When the Pearson r was calculated, the r value was .742, indicating that there was a relatively strong relationship between occupation and the Benevolence dimension (see Table 3.4b). In addition, differences reached the .01 level of significance (p = .002, df = 12) (see Table 3.4b).
Table 3.4b  Report Of Means (X), Standard Deviations (s), Variances (s²), Probability (p), And Pearson's r (r) From The Benevolence Dimension For Subsample One (MSWs) And Subsample Two (MHSWs) (N=87)

<table>
<thead>
<tr>
<th></th>
<th>Subsample One</th>
<th>Subsample Two</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MSWs</td>
<td>MHSWs</td>
</tr>
<tr>
<td>X</td>
<td>132.071</td>
<td>76.929</td>
</tr>
<tr>
<td>s</td>
<td>31.321</td>
<td>16.184</td>
</tr>
<tr>
<td>s²</td>
<td>980.994</td>
<td>261.918</td>
</tr>
</tbody>
</table>

* probability = .002  

r = .742  

degrees of freedom = 12

*p < .01

Therefore, Hypothesis Two which stated that there was a statistically significant difference between the attitudes of MSWs and MHSWs toward mental illness on the Benevolence factor as measured by the Opinions About Mental Illness Scale was not rejected.

Mental Hygiene Ideology

Hypothesis three was related to the Mental Hygiene Ideology dimension. This hypothesis stated that there was a statistically significant difference between the attitudes of MSWs and MHSWs toward mental illness on the Mental Hygiene Ideology factor as measured by the Opinions About Mental Illness Scale.
The Mental Hygiene Ideology dimension consisted of nine survey items. These items are listed below.

Item #

3. Most patients in mental hospitals are not dangerous.

13. Most mental patients are willing to work.

23. If our hospitals had enough well trained doctors, nurses, and aides, many of the patients would get well enough to live outside the hospital.

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

31. The best way to handle patients in mental hospitals is to keep them behind locked doors.

33. The patients of mental hospitals should be allowed more privacy.

38. People (both veterans and non-veterans) who are unable to work because of mental illness should receive money for living expenses.

44. Many people who have never been patients in a mental hospital are more mentally ill than many hospitalized mental patients.

50. Many mental patients would remain in the hospital until they are well, even if the doors are unlocked.
Item #3

When asked if most patients in mental hospitals were not dangerous, of Subsample One (or MSWs), two (or 3.6%) strongly disagreed, while 15 (or 26.8%) disagreed with this statement. Also, 33 (or 59%) agreed, and six (or 10.6%) strongly agreed with this statement (see Table 3.5a). Therefore, the majority (69.6%) of Subsample One (or MSWs) survey respondents strongly agreed or agreed with this statement.

Of Subsample Two (or MHSWs), two (or 6.5%) strongly disagreed, and nine (or 29%) disagreed with this statement. In addition, 16 (or 51.6%) agreed, while four (or 12.9%) strongly agreed with this statement (see Table 3.5a). Therefore, the majority (64.5%) of Subsample Two (or MHSWs) survey respondents strongly agreed or agreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents strongly agreed or agreed with this item.

Item #13

When questioned if most mental patients were willing to work, of Subsample One (or MSWs), three (or 5.4%) strongly disagreed, and 16 (or 28.6%) disagreed with this statement. Meanwhile 35 (or 65.2%) agreed, and two (or 3.5%) strongly agreed with this statement (see Table 3.5a). Therefore, the majority (68.7%) of Subsample One (or MSWs) survey respondents strongly agreed or agreed with this statement.
### Table 3.5a: Responses On The Mental Hygiene Ideology Dimension For Subsample One (MSWs) And Subsample Two (MHSWs) In Numbers (#), And Percents (%) (N=87)

#### SUBSAMPLES

<table>
<thead>
<tr>
<th>Item</th>
<th>SD</th>
<th>D</th>
<th>A</th>
<th>SA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.</td>
<td>2</td>
<td>15</td>
<td>33</td>
<td>6</td>
<td>56</td>
</tr>
<tr>
<td>13.</td>
<td>3</td>
<td>16</td>
<td>35</td>
<td>2</td>
<td>56</td>
</tr>
<tr>
<td>23.</td>
<td>3</td>
<td>16</td>
<td>31</td>
<td>6</td>
<td>56</td>
</tr>
<tr>
<td>28.</td>
<td>2</td>
<td>15</td>
<td>35</td>
<td>4</td>
<td>56</td>
</tr>
<tr>
<td>31.</td>
<td>18</td>
<td>34</td>
<td>4</td>
<td>0</td>
<td>56</td>
</tr>
<tr>
<td>33.</td>
<td>2</td>
<td>20</td>
<td>28</td>
<td>6</td>
<td>56</td>
</tr>
<tr>
<td>38.</td>
<td>0</td>
<td>2</td>
<td>38</td>
<td>16</td>
<td>56</td>
</tr>
<tr>
<td>44.</td>
<td>4</td>
<td>20</td>
<td>25</td>
<td>7</td>
<td>56</td>
</tr>
<tr>
<td>50.</td>
<td>11</td>
<td>21</td>
<td>21</td>
<td>3</td>
<td>56</td>
</tr>
</tbody>
</table>
Table 3.5a  (Continued)

SUBSAMPLES

Two (MHSWs)

| Item | SD | | | D | | | A | | | SA | | | Total |
|------|----|---|---|---|---|---|---|---|---|---|---|---|---|---|
|      | #  | % | #  | % | #  | % | #  | % | #  | % | #  | % |
| 3.   | 2  | 6.5| 9  | 29.0| 16 | 51.6| 4  | 12.9| 31 | 100|
| 13.  | 4  | 12.9| 11 | 35.5| 15 | 48.4| 1  | 3.2 | 31 | 100|
| 23.  | 1  | 3.2| 15 | 48.4| 14 | 45.2| 1  | 3.2 | 31 | 100|
| 28.  | 1  | 3.2| 11 | 35.5| 12 | 38.7| 7  | 23.6| 31 | 100|
| 31.  | 8  | 25.8| 23 | 74.2| 0  | 0.0 | 0  | 0.0 | 31 | 100|
| 33.  | 0  | 0.0| 15 | 48.4| 13 | 41.9| 3  | 9.7 | 31 | 100|
| 38.  | 0  | 0.0| 2  | 6.4 | 22 | 71.0| 7  | 22.6| 31 | 100|
| 44.  | 6  | 19.4| 13 | 41.9| 11 | 35.5| 1  | 3.2 | 31 | 100|
| 50.  | 1  | 3.2| 10 | 32.3| 8  | 25.8| 12 | 38.7| 31 | 100|
Of Subsample Two (or MHSWs), four (or 12.9%) strongly disagreed, and 11 (or 35.5%) disagreed with this statement. In addition, 15 (or 48.4%) agreed, and one (or 3.2%) strongly agreed with this statement (see Table 3.5a). Therefore, the majority (51.6%) of Subsample Two (or MHSWs) survey respondents strongly agreed or agreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents agreed with this item.

Item #23

When asked if our hospitals had enough well trained doctors, nurses, and aides, many of the patients would get well enough to live outside the hospital, of Subsample One (or MSWs), three (or 5.4%) strongly disagreed, while 16 (or 28.6%) disagreed with this statement. Also, 31 (or 55.3%) agreed, and six (or 10.7%) strongly agreed with this statement (see Table 3.5a). Therefore, the majority (66%) of Subsample One (or MSWs) survey respondents strongly agreed or agreed with this statement.

Of Subsample Two (or MHSWs), one (or 3.2%) strongly disagreed, while 15 (or 48.4%) disagreed with this statement. In addition, 14 (or 45.2%) agreed, and one (or 3.2%) strongly agreed with this statement (see Table 3.5a). Therefore, the majority (51.6%) of Subsample Two (or MHSWs) survey respondents strongly disagreed or disagreed with this statement. Consequently, the majority of Subsample One (or MSWs) survey respondents agreed with this item, while the
majority of Subsample Two (or MHSWs) survey respondents disagreed with this item.

**Item #28**

In response to the statement that our mental hospitals seemed more like prisons than like places where mentally ill people can be cared for, of Subsample One (or MSWs), two (or 3.6%) strongly disagreed, and 15 (or 26.8%) disagreed with this statement. Also, 35 (or 62.5%) agreed, while four (or 7.1%) strongly agreed with this statement (see Table 3.5a). Therefore, the majority (69.6%) of Subsample One (or MSWs) survey respondents strongly agreed or agreed with this statement.

Of Subsample Two (or MHSWs), one (or 3.2%) strongly disagreed, while 11 (or 35.5%) disagreed with this statement. In addition, 12 (or 38.7%) agreed, and seven (or 22.6%) strongly agreed with this statement (see Table 3.5a). Therefore, the majority (61.3%) of Subsample Two (or MHSWs) survey respondents strongly agreed or agreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents agreed with this item.

**Item #31**

When questioned if the best way to handle patients in mental hospitals was to keep them behind locked doors, of Subsample One (or MSWs), 18 (or 32.15%) strongly disagreed, while 34 (or 60.7%) disagreed with this statement. Meanwhile, four (or 7.15%) agreed, and none (or 0%) strongly
agreed with this statement (see Table 3.5a). Therefore, the majority (92.85%) of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with this statement.

Of Subsample Two (or MHSWs), eight (or 25.8%) strongly disagreed, and 23 (or 74.2%) disagreed with this statement. Also, none (or 0%) agreed, and none (or 0%) strongly agreed with this statement (see Table 3.5a). Therefore, the majority (100%) of Subsample Two (or MHSWs) survey respondents strongly disagreed or disagreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents disagreed with this item.

Item #33

In response to the statement that the patients of mental hospitals should be allowed more privacy, of Subsample One (or MSWs), two (or 3.6%) strongly disagreed, while 20 (or 35.7%) disagreed with this statement. Also, 28 (or 50%) agreed, and six (or 10.7%) strongly agreed with this statement (see Table 3.5a). Therefore, the majority (60.7%) of Subsample One (or MSWs) survey respondents strongly agreed or agreed with this statement.

Of Subsample Two (or MHSWs), none (or 0%) strongly disagreed, and 15 (or 48.4%) disagreed with this statement. In addition, 13 (or 41.9%) agreed, while three (or 9.7%) strongly agreed with this statement (see Table 3.5a). Therefore, the majority (51.6%) of Subsample Two (or MHSWs)
survey respondents strongly agreed or agreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents agreed with this item.

**Item #38**

When asked if people (both veterans and non-veterans) who were unable to work because of mental illness should receive money for living expenses, of Subsample One (or MSWs), none (or 0%) strongly disagreed, and two (or 3.6%) disagreed with this statement. Meanwhile, 38 (or 67.9%) agreed, and 16 (28.5%) strongly agreed with this statement (see Table 3.5a). Therefore, the majority (96.4%) of Subsample One (or MSWs) survey respondents strongly agreed or agreed with this statement.

Of Subsample Two (or MHSWs), none (or 0%) strongly disagreed, while two (or 6.4%) disagreed with this statement. Also, 22 (or 71%) agreed, and seven (or 22.6%) strongly agreed with this statement (see Table 3.5a). Therefore, the majority (93.6%) of Subsample Two (or MHSWs) survey respondents strongly agreed or agreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents agreed with this item.

**Item #44**

In response to the statement that many people who have never been patients in a mental hospital were more mentally ill than many hospitalized mental patients, of Subsample One
(or MSWs), four (or 7.1%) strongly disagreed, and 20 (or 35.8%) disagreed with this statement. In addition, 25 (or 44.6%) agreed, while seven (or 12.5%) strongly agreed with this statement (see Table 3.5a). Therefore, the majority (57.1%) of Subsample One (or MSWs) survey respondents strongly agreed or agreed with this statement.

Of Subsample Two (or MHSWs), six (or 19.4%) strongly disagreed, while 13 (or 41.9%) disagreed with this statement. Also, 11 (or 35.5%) agreed, and one (or 3.2%) strongly agreed with this statement (see Table 3.5a). Therefore, the majority (61.3%) of Subsample Two (or MHSWs) survey respondents strongly disagreed or disagreed with this statement. Consequently, the majority of Subsample One (or MSWs) survey respondents agreed with this item, while the majority of Subsample Two (or MHSWs) survey respondents disagreed with this item.

**Item #50**

When questioned if many mental patients would remain in the hospital until they were well, even if the doors were unlocked, of Subsample One (or MSWs), 11 (or 19.6%) strongly disagreed, while 21 (or 37.5%) disagreed with this statement. In addition, 21 (or 37.5%) agreed, while three (or 5.4%) strongly agreed with this statement (see Table 3.5a). Therefore, the majority (57.1%) of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with this statement.
Of Subsample Two (or MHSWs), one (or 3.2%) strongly disagreed, and 10 (or 32.3%) disagreed with this statement. Meanwhile, eight (or 25.8%) agreed, and 12 (or 38.7%) strongly agreed with this statement (see Table 3.5a). Therefore, the majority (64.5%) of Subsample Two (or MHSWs) survey respondents strongly agreed or agreed with this statement. Consequently, the majority of Subsample One (or MSWs) survey respondents disagreed with this item, while the majority of Subsample Two (or MHSWs) survey respondents agreed with this item.

Of the nine items in the Mental Hygiene Ideology dimension, Subsamples One and Two (or MSWs and MHSWs) aggregate responses appeared to be the same in six out of nine items. When means were examined, the means for Subsample One (or MSWs) and Subsample Two (or MHSWs) were 142.556 and 77.333, the variances were 343.028 and 155.750, and standard deviations were 18.521 and 12.480 respectively (see Table 3.5b).

When the Pearson r was calculated, the r value was .742, indicating that there was a relatively strong relationship between occupation and the Mental Hygiene Ideology dimension (see Table 3.5b). In addition, differences reached the .05 level of significance (p = .043, df = 7) (see Table 3.5b).

Therefore, Hypothesis Three which stated that there was a statistically significant difference between the attitudes of MSWs and MHSWs toward mental illness on the Mental
Table 3.5b  Report Of Means (\(\bar{X}\)), Standard Deviations (s), Variances (s\(^2\)), Probability (p), And Pearson's r (r) From The Mental Hygiene Ideology Dimension For Subsample One (MSWs) and Subsample Two (MHSWs) (N=87)

<table>
<thead>
<tr>
<th>Subsample One</th>
<th>Subsample Two</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>MSWs</td>
<td>MHSWs</td>
</tr>
<tr>
<td>(\bar{X})</td>
<td>(\bar{X})</td>
</tr>
<tr>
<td>142.556</td>
<td>77.333</td>
</tr>
<tr>
<td>s</td>
<td>s</td>
</tr>
<tr>
<td>18.521</td>
<td>12.480</td>
</tr>
<tr>
<td>s(^2)</td>
<td>s(^2)</td>
</tr>
<tr>
<td>343.028</td>
<td>155.750</td>
</tr>
</tbody>
</table>

* probability = .043
r = .742
degrees of freedom = 7

*\(p < .05\)

Hygiene Ideology factor as measured by the Opinions About Mental Illness Scale was not rejected.

Social Restrictiveness

Hypothesis four was related to the Social Restrictiveness dimension. This hypothesis stated that there was a statistically significant difference between the attitudes of MSWs and MHSWs toward mental illness on the Social Restrictiveness factor as measured by the Opinions About Mental Illness Scale. The Social Restrictiveness dimension included 10 survey items. These items are listed below.
Item #

4. ALTHOUGH PATIENTS DISCHARGED FROM MENTAL HOSPITALS MAY SEEM ALL RIGHT, THEY SHOULD NOT BE ALLOWED TO MARRY.

7. PEOPLE WHO ARE MENTALLY ILL LET THEIR EMOTIONS CONTROL THEM; 'NORMAL' PEOPLE THINK THINGS OUT.

8. PEOPLE WHO WERE ONCE PATIENTS IN MENTAL HOSPITALS ARE NO MORE DANGEROUS THAN THE AVERAGE CITIZEN.

14. THE SMALL CHILDREN OF PATIENTS IN MENTAL HOSPITALS SHOULD NOT BE ALLOWED TO VISIT THEM.

24. A WOMAN WOULD BE FOOLISH TO MARRY A MAN WHO HAS HAD A SEVERE MENTAL ILLNESS, EVEN THOUGH HE SEEMS FULLY RECOVERED.

29. ANYONE WHO IS IN A HOSPITAL FOR A MENTAL ILLNESS SHOULD NOT BE ALLOWED TO VOTE.

41. MOST WOMEN WHO WERE ONCE PATIENTS IN A MENTAL HOSPITAL COULD NOT BE TRUSTED AS BABYSITTERS.

42. MOST PATIENTS IN MENTAL HOSPITALS DO NOT CARE HOW THEY LOOK.

45. ALTHOUGH SOME MENTAL PATIENTS SEEM ALL RIGHT, IT IS DANGEROUS TO FORGET FOR A MOMENT THAT THEY ARE MENTALLY ILL.

51. ALL PATIENTS IN MENTAL HOSPITALS SHOULD BE PREVENTED FROM HAVING CHILDREN BY A PAINLESS OPERATION.
Item #4

In response to the statement that although patients discharged from mental hospitals may seem all right, they should not be allowed to marry, of Subsample One (or MSWs), 23 (or 41.1%) strongly disagreed, and 23 (or 41.1%) disagreed with this statement. In addition, nine (or 16%) agreed, while one (or 1.8%) strongly agreed with this statement (see Table 3.6a). Therefore, the majority (82.2%) of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with this statement.

Of Subsample Two (or MHSWs), 15 (or 48.4%) strongly disagreed, while 15 (or 48.4%) disagreed with this statement. Also, one (or 3.2%) agreed, and none (or 0%) strongly agreed with this statement (see Table 3.6a). Therefore, the majority (96.8%) of Subsample Two (or MHSWs) survey respondents strongly disagreed or disagreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents disagreed with this item.

Item #7

When asked if people who were mentally ill let their emotions control them; 'normal' people thought things out, of Subsample One (or MSWs), eight (or 14.3%) strongly disagreed, while 33 (or 58.9%) disagreed with this statement. Meanwhile, 15 (or 26.8%) agreed, and none (or 0%) strongly agreed with this statement (see Table 3.6a). Therefore, the majority (73.2%) of Subsample One (or MSWs)
Table 3.6a  Responses On The Social Restrictiveness Dimension For Subsample One (MSWs)
And Subsample Two (MHSWs) In Numbers (#), And Percents (%) (N=87)

<table>
<thead>
<tr>
<th>Item</th>
<th>SD</th>
<th>D</th>
<th>A</th>
<th>SA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.</td>
<td>23</td>
<td>23</td>
<td>9</td>
<td>1</td>
<td>56</td>
</tr>
<tr>
<td>7.</td>
<td>8</td>
<td>33</td>
<td>15</td>
<td>0</td>
<td>56</td>
</tr>
<tr>
<td>8.</td>
<td>4</td>
<td>25</td>
<td>25</td>
<td>2</td>
<td>56</td>
</tr>
<tr>
<td>14.</td>
<td>9</td>
<td>23</td>
<td>17</td>
<td>7</td>
<td>56</td>
</tr>
<tr>
<td>24.</td>
<td>5</td>
<td>20</td>
<td>19</td>
<td>12</td>
<td>56</td>
</tr>
<tr>
<td>29.</td>
<td>9</td>
<td>30</td>
<td>14</td>
<td>3</td>
<td>56</td>
</tr>
<tr>
<td>41.</td>
<td>4</td>
<td>22</td>
<td>25</td>
<td>5</td>
<td>56</td>
</tr>
<tr>
<td>42.</td>
<td>6</td>
<td>13</td>
<td>18</td>
<td>1</td>
<td>56</td>
</tr>
<tr>
<td>45.</td>
<td>5</td>
<td>24</td>
<td>24</td>
<td>3</td>
<td>56</td>
</tr>
<tr>
<td>51.</td>
<td>27</td>
<td>28</td>
<td>1</td>
<td>0</td>
<td>56</td>
</tr>
</tbody>
</table>

SUBSAMPLES

One (MSWs)
Table 3.6a  (Continued)

<table>
<thead>
<tr>
<th>Item</th>
<th>SD #</th>
<th>SD %</th>
<th>D #</th>
<th>D %</th>
<th>A #</th>
<th>A %</th>
<th>SA #</th>
<th>SA %</th>
<th>Total #</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>15</td>
<td>48.4</td>
<td>15</td>
<td>48.4</td>
<td>1</td>
<td>3.2</td>
<td>0</td>
<td>0.0</td>
<td>31</td>
<td>100</td>
</tr>
<tr>
<td>7</td>
<td>3</td>
<td>9.7</td>
<td>25</td>
<td>80.6</td>
<td>2</td>
<td>6.5</td>
<td>1</td>
<td>3.2</td>
<td>31</td>
<td>100</td>
</tr>
<tr>
<td>8</td>
<td>7</td>
<td>23.0</td>
<td>11</td>
<td>36.0</td>
<td>12</td>
<td>38.0</td>
<td>1</td>
<td>3.0</td>
<td>31</td>
<td>100</td>
</tr>
<tr>
<td>14</td>
<td>8</td>
<td>25.8</td>
<td>10</td>
<td>32.3</td>
<td>6</td>
<td>19.4</td>
<td>7</td>
<td>22.5</td>
<td>31</td>
<td>100</td>
</tr>
<tr>
<td>24</td>
<td>1</td>
<td>3.2</td>
<td>11</td>
<td>35.5</td>
<td>10</td>
<td>32.3</td>
<td>9</td>
<td>29.0</td>
<td>31</td>
<td>100</td>
</tr>
<tr>
<td>29</td>
<td>7</td>
<td>22.6</td>
<td>24</td>
<td>77.4</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>31</td>
<td>100</td>
</tr>
<tr>
<td>41</td>
<td>4</td>
<td>12.9</td>
<td>16</td>
<td>51.6</td>
<td>10</td>
<td>32.3</td>
<td>1</td>
<td>3.2</td>
<td>31</td>
<td>100</td>
</tr>
<tr>
<td>42</td>
<td>2</td>
<td>6.0</td>
<td>15</td>
<td>48.0</td>
<td>11</td>
<td>35.0</td>
<td>3</td>
<td>11.0</td>
<td>31</td>
<td>100</td>
</tr>
<tr>
<td>45</td>
<td>3</td>
<td>9.7</td>
<td>15</td>
<td>48.4</td>
<td>5</td>
<td>16.1</td>
<td>8</td>
<td>25.8</td>
<td>31</td>
<td>100</td>
</tr>
<tr>
<td>51</td>
<td>8</td>
<td>25.8</td>
<td>23</td>
<td>74.2</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>31</td>
<td>100</td>
</tr>
</tbody>
</table>
survey respondents strongly disagreed or disagreed with this statement.

Of Subsample Two (or MHSWs), three (or 9.7%) strongly disagreed, and 25 (or 80.6%) disagreed with this statement. Also, two (or 6.5%) agreed, and one (or 3.2%) strongly agreed with this statement (see Table 3.6a). Therefore, the majority (90.3%) of Subsample Two (or MHSWs) survey respondents strongly disagreed or disagreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents disagreed with this item.

**Item #8**

When questioned if people who were once patients in mental hospitals were no more dangerous than the average citizen, of Subsample One (or MSWs), four (or 7.1%) strongly disagreed, and 25 (or 44.6%) disagreed with this statement. In addition, 25 (or 44.6%) agreed, and two (or 3.7%) strongly agreed with this statement (see Table 3.6a). Therefore, the majority (51.7%) of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with this statement.

Of Subsample Two (or MHSWs), seven (or 23%) strongly disagreed, while 11 (or 36%) disagreed with this statement. Meanwhile, 12 (or 38%) agreed, and one (or 3%) strongly agreed with this statement (see Table 3.6a). Therefore, the majority (59%) of Subsample Two (or MHSWs) survey respondents strongly disagreed or disagreed with this
Item #14

In response to the statement that the small children of patients in mental hospitals should not be allowed to visit them, of Subsample One (or MSWs), nine (or 16%) strongly disagreed, and 23 (or 41.1%) disagreed with this statement. Also, 17 (or 30.4%) agreed, while seven (or 12.5%) strongly agreed with this statement (see Table 3.6a). Therefore, the majority (57.1%) of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with this statement.

Of Subsample Two (or MHSWs), eight (or 25.8%) strongly disagreed, and 10 (or 32.3%) disagreed with this statement. In addition, six (or 19.4%) agreed, and seven (or 22.5%) strongly agreed with this statement (see Table 3.6a). Therefore, the majority (58.1%) of Subsample Two (or MHSWs) survey respondents strongly disagreed or disagreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents disagreed with this statement.

Item #24

When asked if a woman would be foolish to marry a man who has had a severe mental illness, even though he seemed fully recovered, of Subsample One (or MSWs), five (or 8.9%) strongly disagreed, and 20 (or 35.7%) disagreed with this
statement. Also, 19 (or 33.9%) agreed, while 12 (or 21.5%) strongly agreed with this statement (see Table 3.6a). Therefore, the majority (55.4%) of Subsample One (or MSWs) survey respondents strongly agreed or agreed with this statement.

Of Subsample Two (or MHSWs), one (or 3.2%) strongly disagreed, while 11 (or 35.5%) disagreed with this statement. In addition, 10 (or 32.3%) agreed, while nine (or 29%) strongly agreed with this statement (see Table 3.6a). Therefore, the majority (61.3%) of Subsample Two (or MHSWs) survey respondents strongly agreed or agreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents agreed with this item.

**Item #29**

In response to the statement that anyone who was in a hospital for a mental illness should not be allowed to vote, of Subsample One (or MSWs), nine (or 16.1%) strongly disagreed, and 30 (or 53.6%) disagreed with this statement. Meanwhile, 14 (or 25%) agreed, and three (or 5.3%) strongly agreed with this statement (see Table 3.6a). Therefore, the majority (69.7%) of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with this statement.

Of Subsample Two (or MHSWs), seven (or 22.6%) strongly disagreed, and 24 (or 77.4%) disagreed with this statement. Also, none (or 0%) agreed, and none (or 0%) strongly agreed
with this statement (see Table 3.6a). Therefore, the majority (100%) of Subsample Two (or MHSWs) survey respondents strongly disagreed or disagreed with this item. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents disagreed with this item.

Item #41

When questioned if most women who were once patients in a mental hospital could not be trusted as babysitters, of Subsample One (or MSWs), four (or 7.1%) strongly disagreed, and 22 (or 39.35%) disagreed with this statement. Also, 25 (or 44.65%) agreed, while five (or 8.9%) strongly agreed with this statement (see Table 3.6a). Therefore, the majority (53.55%) of Subsample One (or MSWs) survey respondents strongly agreed or agreed with this statement.

Of Subsample Two (or MHSWs), four (or 12.9%) strongly disagreed, and 16 (or 51.6%) disagreed with this statement. In addition, 10 (or 32.3%) agreed, while one (or 3.2%) strongly agreed with this statement (see Table 3.6a). Therefore, the majority (64.5%) of Subsample Two (or MHSWs) survey respondents strongly disagreed or disagreed with this statement. Consequently, the majority of Subsample One (or MSWs) survey respondents agreed with this item, while the majority of Subsample Two (or MHSWs) survey respondents disagreed with this item.
Item #42

In response to the statement that most patients in mental hospitals did not care how they looked, of Subsample One (or MSWs), six (or 10.7%) strongly disagreed, while 13 (or 55.3%) disagreed with this statement. Meanwhile, 18 (or 28.6%) agreed, and one (or 5.4%) strongly agreed with this statement (see Table 3.6a). Therefore, the majority (66%) of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with this statement.

Of Subsample Two (or MHSWs), two (or 6%) strongly disagreed, and 15 (or 48%) disagreed with this statement. In addition, 11 (or 35%) agreed, and three (or 11%) strongly agreed with this statement (see Table 3.6a). Therefore, the majority (54%) of Subsample Two (or MHSWs) survey respondents strongly disagreed or disagreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents disagreed with this item.

Item #45

In response to the statement that although some mental patients seemed all right, it was dangerous to forget for a moment that they were mentally ill, of Subsample One (or MSWs), five (or 8.9%) strongly disagreed, while 24 (or 42.9%) disagreed with this statement. Also, 24 (or 42.9%) agreed, and three (or 5.3%) strongly agreed with this statement (see Table 3.6a). Therefore, the majority (51.8%)
of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with this statement.

Of Subsample Two (or MHSWs), three (or 9.7%) strongly disagreed, and 15 (or 48.4%) disagreed with this statement. In addition, five (or 16.1%) agreed, and eight (or 25.8%) strongly agreed with this statement (see Table 3.6a). Therefore, the majority (58.1%) of Subsample Two (or MHSWs) survey respondents strongly disagreed or disagreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents disagreed with this item.

**Item #51**

When asked if all patients in mental hospitals should be prevented from having children by a painless operation, of Subsample One (or MSWs), 27 (or 48.2%) strongly disagreed, and 28 (or 50%) disagreed with this statement. Meanwhile, one (or 1.8%) agreed, and none (or 0%) strongly agreed with this statement (see Table 3.6a). Therefore, the majority (98.2%) of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with this statement.

Of Subsample Two (or MHSWs), eight (or 25.8%) strongly disagreed, while 23 (or 74.2%) disagreed with this statement. Also, none (or 0%) agreed, and none (or 0%) strongly agreed with this statement (see Table 3.6a). Therefore, the majority (100%) of Subsample Two (or MHSWs) survey respondents strongly disagreed or disagreed with this statement.
statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents disagreed with this item.

Of the 10 items in the Social Restrictiveness dimension, Subsamples One and Two (or MSWs and MHSWs) aggregate responses appeared to be the same in nine out of 10 items. When means were examined, the means for Subsample One (or MSWs) and Subsample Two (or MHSWs) were 124.400 and 67.100, the variances were 465.822 and 151.211, and standard deviations were 21.583 and 12.297 respectively (see Table 3.6b).

When the Pearson r was calculated, the r value was .833, indicating that there was a relatively very strong relationship between occupation and the Social Restrictiveness dimension (see Table 3.6b). In addition, differences reached the .01 level of significance (p = .002, df = 8)(see Table 3.6b).

Therefore, Hypothesis Four which stated that there was a statistically significant difference between the attitudes of MSWs and MHSWs toward mental illness on the Social Restrictiveness factor as measured by the Opinions About Mental Illness Scale was not rejected.

Interpersonal Etiology

Hypothesis five was related to the Interpersonal Etiology dimension. This hypothesis stated that there was a statistically significant difference between the attitudes
Table 3.6b Report Of Means (\(\bar{x}\)), Standard Deviations (s), Variances (s²), Probability (p), And Pearson's r (r) From The Social Restrictiveness Dimension For Subsample One (MSWs) And Subsample Two (MHSWs) (N=87)

<table>
<thead>
<tr>
<th>Subsample One</th>
<th>Subsample Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSWs</td>
<td>MHSWs</td>
</tr>
<tr>
<td>(\bar{x})</td>
<td>(\bar{x})</td>
</tr>
<tr>
<td>124.400</td>
<td>67.100</td>
</tr>
<tr>
<td>s</td>
<td>s</td>
</tr>
<tr>
<td>21.583</td>
<td>12.297</td>
</tr>
<tr>
<td>s²</td>
<td>s²</td>
</tr>
<tr>
<td>465.822</td>
<td>151.211</td>
</tr>
</tbody>
</table>

* probability = .002

r = .833

degrees of freedom = 8

*p < .01

of MSWs and MHSWs toward mental illness on the Interpersonal Etiology factor as measured by the Opinions About Mental Illness Scale. The Interpersonal Etiology dimension consisted of seven survey items. These items are listed below.

Item #

5. IF PARENTS LOVED THEIR CHILDREN MORE, THERE WOULD BE LESS MENTAL ILLNESS.

10. ALTHOUGH THEY USUALLY ARE NOT AWARE OF IT, MANY PEOPLE BECOME MENTALLY ILL TO AVOID THE DIFFICULT PROBLEMS OF EVERYDAY LIFE.

15. PEOPLE WHO ARE SUCCESSFUL IN THEIR WORK SELDOM BECOME MENTALLY ILL.
20. MENTAL PATIENTS COME FROM HOMES WHERE THE PARENTS TOOK LITTLE INTEREST IN THEIR CHILDREN.

25. IF THE CHILDREN OF MENTALLY ILL PARENTS WERE RAISED BY 'NORMAL' PARENTS, THEY WOULD PROBABLY NOT BECOME MENTALLY ILL.

30. THE MENTAL ILLNESS OF MANY PEOPLE IS CAUSED BY THE SEPARATION OR DIVORCE OF THEIR PARENTS DURING CHILDHOOD.

35. IF THE CHILDREN OF 'NORMAL' PARENTS WERE RAISED BY MENTALLY ILL PARENTS, THEY WOULD PROBABLY BECOME MENTALLY ILL.

Item #5

When questioned if parents loved their children more, there would be less mental illness, of Subsample One (or MSWs), 15 (or 26.8%) strongly disagreed, and 20 (or 35.7%) disagreed with this statement. Meanwhile, 21 (or 37.5%) agreed, and none (or 0%) strongly agreed with this statement (see Table 3.7a). Therefore, the majority (62.5%) of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with this statement.

Of Subsample Two (or MHSWs), six (or 19%) strongly disagreed, while 17 (or 55%) disagreed with this statement. In addition, seven (or 23%) agreed, and one (or 3%) strongly agreed with this statement. Therefore, the majority (74%) of Subsample Two (or MHSWs) survey respondents strongly disagreed or disagreed with this statement (see Table 3.7a).
Table 3.7a  Responses On The Interpersonal Etiology Dimension For Subsample One (MSWs) And Subsample Two (MHSWs) In Numbers (#), And Percents (%) (N=87)

SUBSAMPLES

One (MSWs)

<table>
<thead>
<tr>
<th>Item</th>
<th>SD</th>
<th></th>
<th>D</th>
<th></th>
<th>A</th>
<th></th>
<th>SA</th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>5.</td>
<td>15</td>
<td>26.8</td>
<td>20</td>
<td>35.7</td>
<td>21</td>
<td>37.5</td>
<td>0</td>
<td>0.0</td>
<td>56</td>
</tr>
<tr>
<td>10.</td>
<td>11</td>
<td>20.0</td>
<td>14</td>
<td>25.0</td>
<td>28</td>
<td>50.0</td>
<td>3</td>
<td>5.0</td>
<td>56</td>
</tr>
<tr>
<td>15.</td>
<td>9</td>
<td>16.1</td>
<td>33</td>
<td>58.9</td>
<td>14</td>
<td>25.0</td>
<td>0</td>
<td>0.0</td>
<td>56</td>
</tr>
<tr>
<td>20.</td>
<td>7</td>
<td>12.5</td>
<td>36</td>
<td>64.3</td>
<td>12</td>
<td>21.4</td>
<td>1</td>
<td>1.8</td>
<td>56</td>
</tr>
<tr>
<td>25.</td>
<td>2</td>
<td>3.6</td>
<td>37</td>
<td>66.1</td>
<td>15</td>
<td>26.8</td>
<td>2</td>
<td>3.6</td>
<td>56</td>
</tr>
<tr>
<td>30.</td>
<td>7</td>
<td>12.5</td>
<td>34</td>
<td>60.7</td>
<td>14</td>
<td>25.0</td>
<td>1</td>
<td>1.8</td>
<td>56</td>
</tr>
<tr>
<td>35.</td>
<td>6</td>
<td>5.4</td>
<td>26</td>
<td>46.4</td>
<td>21</td>
<td>37.5</td>
<td>3</td>
<td>10.7</td>
<td>56</td>
</tr>
</tbody>
</table>
Table 3.7a  (Continued)

**SUBSAMPLES**

Two (MHSWs)

<table>
<thead>
<tr>
<th>Item</th>
<th>SD</th>
<th>%</th>
<th>D</th>
<th>%</th>
<th>A</th>
<th>%</th>
<th>SA</th>
<th>%</th>
<th>Total</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.</td>
<td>6</td>
<td>19.0</td>
<td>17</td>
<td>55.0</td>
<td>7</td>
<td>23.0</td>
<td>1</td>
<td>3.0</td>
<td>31</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>11</td>
<td>35.4</td>
<td>6</td>
<td>19.4</td>
<td>9</td>
<td>29.0</td>
<td>5</td>
<td>16.2</td>
<td>31</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>8</td>
<td>25.8</td>
<td>18</td>
<td>58.1</td>
<td>4</td>
<td>12.9</td>
<td>1</td>
<td>3.2</td>
<td>31</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>6</td>
<td>19.35</td>
<td>23</td>
<td>74.2</td>
<td>2</td>
<td>6.45</td>
<td>0</td>
<td>0.0</td>
<td>31</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>3</td>
<td>9.7</td>
<td>24</td>
<td>77.4</td>
<td>2</td>
<td>6.5</td>
<td>2</td>
<td>6.4</td>
<td>31</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>30.</td>
<td>4</td>
<td>12.9</td>
<td>19</td>
<td>61.3</td>
<td>5</td>
<td>16.1</td>
<td>3</td>
<td>9.7</td>
<td>31</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>35.</td>
<td>1</td>
<td>3.2</td>
<td>19</td>
<td>61.3</td>
<td>8</td>
<td>25.8</td>
<td>3</td>
<td>9.7</td>
<td>31</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>
Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents disagreed with this item.

**Item #10**

In response to the statement that although they usually were not aware of it, many people become mentally ill to avoid the difficult problems of everyday life, of Subsample One (or MSWs), 11 (or 20%) strongly disagreed, and 14 (25%) disagreed with this statement. Also, 28 (or 50%) agreed, while three (or 5%) strongly agreed with this statement (See Table 3.7a). Therefore, the majority (55%) of Subsample One (or MSWs) survey respondents strongly agreed or agreed with this statement.

Of Subsample Two (or MHSWs), 11 (or 35.4%) strongly disagreed, and six (or 19.4%) disagreed. In addition, nine (or 29%) agreed, and five (or 16.2%) strongly agreed with this statement (see Table 3.7a). Therefore, the majority (54.8%) of Subsample Two (or MHSWs) survey respondents strongly disagreed or disagreed with this statement. Consequently, the majority of Subsample One (or MSWs) survey respondents agreed with this item, while the majority of Subsample Two (or MHSWs) survey respondents disagreed with this item.

**Item #15**

When asked if people who were successful in their work seldom become mentally ill, of Subsample One (or MSWs), nine (or 16.1%) strongly disagreed, and 33 (or 58.9%) disagreed
with this statement. Meanwhile, 14 (or 25%) agreed, and
none (or 0%) strongly agreed with this statement (see Table
3.7a). Therefore, the majority (75%) of Subsample One (or
MSWs) survey respondents strongly disagreed or disagreed
with this statement.

Of Subsample Two (or MHSWs), eight (or 25.8%) strongly
disagreed, while 18 (or 58.1%) disagreed with this
statement. Also, four (or 12.9%) agreed, and one (or 3.2%)
strongly agreed with this statement (see Table 3.7a).
Therefore, the majority (83.9%) of Subsample Two (or MHSWs)
survey respondents strongly disagreed or disagreed with this
statement. Consequently, the majority of Subsamples One and
Two (MSWs and MHSWs) survey respondents disagreed with this
statement.

Item #20

In response to the statement that mental patients came
from homes where the parents took little interest in their
children, of Subsample One (or MSWs), seven (or 12.5%)
strongly disagreed, and 36 (or 64.3%) disagreed with this
statement (see Table 3.7a). In addition, 12 (or 21.4%)
agreed, and one (or 1.8%) strongly agreed with this
statement (see Table 3.7a). Therefore, the majority (76.8%)
of Subsample One (or MSWs) survey respondents strongly
disagreed or disagreed with this statement.

Of Subsample Two (or MHSWs), six (or 19.35) strongly
disagreed, while 23 (or 74.2%) disagreed with this
statement. Also, two (or 6.45%) agreed, and none (or 0%)
strongly agreed with this statement (see Table 3.7a). Therefore, the majority (93.55%) of Subsample Two (or MHSWs) survey respondents disagreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents disagreed with this statement.

**Item #25**

When questioned if the children of mentally ill parents were raised by 'normal' parents, they would probably not become mentally ill, of Subsample One (or MSWs), two (or 3.6%) strongly disagreed, and 37 (or 66.1%) disagreed with this statement. Also, 15 (or 26.8%) agreed, while two (or 3.6%) strongly agreed with this statement (see Table 3.7a). Therefore, the majority (69.7%) of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with this statement.

Of Subsample Two (or MHSWs), three (or 9.7%) strongly disagreed, while 24 (or 77.4%) disagreed with this statement. In addition, two (or 6.5%) agreed, and two (or 6.4%) strongly agreed with this statement (see Table 3.7a). Therefore, the majority (87.1%) of Subsample Two (or MHSWs) survey respondents disagreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents disagreed with this item.

**Item #30**

In response to the statement that the mental illness of many people was caused by the separation or divorce of their
parents during childhood, of Subsample One (or MSWs), seven (or 12.5%) strongly disagreed, while 34 (or 60.7%) disagreed with this statement. Meanwhile, 14 (or 25%) agreed, and one (or 1.8%) strongly agreed with this statement (see Table 3.7a). Therefore, the majority (73.2%) of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with this statement.

Of Subsample Two (or MHSWs), four (or 12.9%) strongly disagreed, and 19 (or 61.3%) disagreed with this statement. Also, five (or 16.1%) agreed, while three (or 9.7%) strongly agreed with this statement (see Table 3.7a). Therefore, the majority (74.2%) of Subsample Two (or MHSWs) survey respondents strongly disagreed or disagreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents disagreed with this item.

**Item #35**

When asked if the children of 'normal' parents were raised by mentally ill parents, they would probably become mentally ill, of Subsample One (or MSWs), six (or 5.4%) strongly disagreed, and 26 (or 46.4%) disagreed with this statement. Also, 21 (or 37.5%) agreed, while three (or 10.7%) strongly agreed with this statement (see Table 3.7a). Therefore, the majority (51.8%) of Subsample One (or MSWs) survey respondents strongly disagreed or disagreed with this statement.
Of Subsample Two (or MHSWs), one (or 3.2%) strongly disagreed, and 19 (or 61.3%) disagreed with this statement. In addition, eight (or 25.8%) agreed, and three (or 9.7%) strongly agreed with this statement (see Table 3.7a). Therefore, the majority (64.5%) of Subsample Two (or MHSWs) survey respondents disagreed with this statement. Consequently, the majority of Subsamples One and Two (or MSWs and MHSWs) survey respondents disagreed with this item.

Of the seven items in the Interpersonal Etiology dimension, Subsamples One and Two (or MSWs and MHSWs) aggregate responses appeared to be the same in six out of seven items. When the means were examined, the means for Subsample One (or MSWs) and Subsample Two (or MHSWs) were 127.429 and 65.857, the variances were 43.952 and 35.143, and standard deviations were 6.630 and 5.928 respectively (see Table 3.7b).

When the Pearson r was calculated, the r value was .757, indicating a relatively very strong relationship between occupation and the Interpersonal Etiology dimension (see Table 3.7b). In addition, differences reached the .05 level of significance ($p = .048$, df = 5) (see Table 3.7b).

Therefore, Hypothesis Five which stated there was a statistically significant difference between the attitudes of MSWs and MHSWs toward mental illness on the Interpersonal Etiology factor as measured by the Opinions About Mental Illness Scale was not rejected.
Table 3.7b Report Of Means ($\bar{x}$), Standard Deviations (s), Variances ($s^2$), Probability (p), And Pearson's r (r) From The Interpersonal Etiology Dimension For Subsample One (MSWs) And Subsample Two (MHSWs) (N=87)

<table>
<thead>
<tr>
<th>Subsample One</th>
<th>Subsample Two</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>MSWs</td>
<td>MHSWs</td>
</tr>
<tr>
<td>$\bar{x}$</td>
<td>$\bar{x}$</td>
</tr>
<tr>
<td>127.429</td>
<td>65.857</td>
</tr>
<tr>
<td>s</td>
<td>s</td>
</tr>
<tr>
<td>6.630</td>
<td>5.928</td>
</tr>
<tr>
<td>$s^2$</td>
<td>$s^2$</td>
</tr>
<tr>
<td>43.952</td>
<td>35.143</td>
</tr>
</tbody>
</table>

* * probability = .048
r = .757
degrees of freedom = 5

* $p < .05$

Summary: Survey Results

In consequence, of the five dimensions included on the Opinions About Mental Illness Scale, three reached significance (see Table 3.8). These were Benevolence ($p < .01$), Mental Hygiene Ideology ($p < .05$), Social Restrictiveness ($p < .01$), and Interpersonal Etiology ($p < .05$) (see Table 3.8). The dimension that did not reach significance was Authoritarianism ($p > .05$) (see Table 3.8).
Table 3.8 Report of Significance on Five Dimensions of the Opinions About Mental Illness Scale and Related Hypotheses

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Significance</th>
<th>Hypothesis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Authoritarianism</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>2. Benevolence</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>3. Mental Hygiene Ideology</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>4. Social Restrictiveness</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>5. Interpersonal Etiology</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
CHAPTER IV

Discussion

The purpose of this study was to compare the attitudes of medical social workers (MSWs) and mental health social workers (MHSWs) toward mental illness. In patient care, it may be assumed that MSWs rely on the disease model, whereas MHSWs rely on a model that is blame oriented. These social workers were of particular interest since their attitudes toward mental illness may influence patient care. Moreover, there was a need to contribute to the limited amount of literature regarding social workers’ attitudes toward mental illness.

Results acquired will be discussed according to the five dimensions of interest in this study. These were Authoritarianism, Benevolence, Mental Hygiene Ideology, Social Restrictiveness, and Interpersonal Etiology.

Survey respondents could select from among four responses, for each of the 51 survey items. The four responses were (SD) strongly disagree, (D) disagree, (A) agree, and (SA) strongly agree. Survey respondents were instructed to select the one response that best reflected their opinion. Summary/conclusions and implications for future research will conclude this chapter.
Authoritarianism

Authoritarianism described the view that the mentally ill are perceived as unlike and inferior to 'normal' persons. The first study hypothesis stated that there was a statistically significant difference between the attitudes of MSWs and MHSWs toward mental illness on the Authoritarianism factor. This hypothesis was rejected (refer to Tables 3.3b and 3.8).

MSWs and MHSWs scored less on survey items in the Authoritarianism dimension. In consequence, this sample held nonauthoritarian attitudes concerning the mentally ill. These social workers perceived mental patients as similar and equal to 'normal' individuals which may impact patient care.

It appears that these social workers would treat the patient as a 'normal' individual, with respect and dignity, and be considerate of the patient's rights. This finding can be viewed as positive. Since the social worker may communicate, verbally or nonverbally this attitude to the patient. A social worker with this attitude would enhance the therapeutic relationship. For example, the patient is seen as equal to others. This attitude may foster communication that may assist the patient in perceiving him/herself as equal to others. This may also lead to improving the patient's self-esteem and ultimately, his/her social functioning. This would aid the patient's
rehabilitation, while increasing chances for stabilization of illness.

This finding is similar to that of Cohen and Struening (1962 and 1963), in which social workers scored low on Authoritarianism. However, in this study, there were only 19 social workers in the sample. Findings as they pertained to social workers treating patients were not examined.

It was surprising to find that MSWs and MHSWs appeared to have the same scores on certain survey items. Of particular interest was Item #48 (refer to Table 3.3a). This item stated that one of the main causes of mental illness was a lack of moral strength or willpower.

Both MSWs and MHSWs disagreed with this statement. For MSWs this finding was expected. Being trained from the disease model, the patient is generally viewed as someone with an illness rather than a weakness that is generally attributed to low morals or lack of willpower. However, for MHSWs, this finding was surprising, because they were trained from a model that was blame oriented. The patient would have been blamed for his/her illness, and it would thus be assumed that the patient caused this illness by personal attitudes or actions. Based on this belief, it was expected that MHSWs would have agreed with this statement, but this was not the finding.

Since college, these MHSWs may have received additional education and training by enrolling in graduate courses, attending inservice training, and seminars that provided
more accurate knowledge on mental illness. This information may have nullified some of the precepts in the blame oriented perspective, such as mental illness could have been attributed to moral weakness and/or lack of willpower. It appears that viewing the illness as a disease, rather than a sign of moral weakness is positive. For example, the social worker may be less judgmental. S/he may be less likely to damage the patient's self-esteem, thereby improving the patient's chance for recovery.

MSWs and MHSWs appeared to have different scores on another item of interest. This was Item #39 (see Table 3.3a). This item stated that mental illness was usually caused by some disease of the nervous system. For MSWs to have disagreed with this statement was surprising. MSWs are trained in the disease model. Therefore, they were expected to have agreed with this statement. However, this finding is, in effect, plausible, since the majority of MSWs had 10-15 years of experience in medical social work (see Table 3.2a).

Yet, this finding could be viewed as negative, since results suggest that these MSWs may have forgotten this teaching. In addition, their attitudes have changed such that they have abandoned this belief. This may be attributed to other training and/or association with other mental health professionals who bore this type of attitude.

Since these MSWs did not hold the belief that mental illness was usually caused by some disease of the nervous
system, this finding indicated that these MSWs may have adopted another treatment model. Whether or not this finding is positive or negative depends upon the treatment perspective utilized by these MSWs.

If it was a model that was blame oriented, then such an attitude could potentially have detrimental effects on patient care. Because the social worker may have blamed the patient for his/her illness, guilty feelings may have resulted. This may result in lowering the patient's self-esteem. In this case, the patient may not attempt to function in healthier roles, thereby remaining sick with few chances of improvement.

However, if a model was employed that perceived the patient as equal to others and did not fault the patient for the illness, this may be a healthy approach. This approach would then provide the mental patient with treatment that can elevate self-esteem and promote optimism that this disease is treatable. Additionally, the patient does not have to remain in the sick role. This would increase opportunities for improvement.

For MHSWs to have agreed with this statement was surprising, because their training was opposed to such a belief. Rather than mental illness being caused by some disease of the nervous system, the blame oriented model taught that mental illness was caused by the individual's inability to cope in his/her environment. This places the blame for illness on the patient. This finding suggests
that these MHSWs may have acquired more accurate knowledge about mental illness through graduate courses and seminars and/or affiliation with settings having a differential attitude perspective. This finding should be perceived as positive, it may also indicate that these MHSWs have begun to adhere to the disease or a similar model. As stated previously, this would improve patient care, because it would treat mental illness as a disease and encourage patients to perform in healthier roles. This would also have the potential to aid in the patient's improvement.

On the Authoritarianism dimension, these MSWs and MHSWs perceived mental patients as similar and equal to 'normal' individuals. This result may be attributed to race and sex, since the majority of these MSWs and MHSWs were Black females (see Table 3.0a). These individuals may be nonauthoritarian in nature because they have traditionally held subordinate roles in society. Hence, they may have been identifying with the mentally ill as an underdog. Therefore, they would desire to treat these persons as they want to be treated, equally.

Overall, this nonauthoritarian attitude should be viewed as positive, because these social workers may treat mental patients as 'normal' individuals. This treatment may increase the probability that the patient would recover normal functioning. The patient would not be considered inferior. S/he would have been encouraged to function as a
'normal' person, thus discarding the sick role and increasing the probability of approaching recovery.

**Benevolence**

Benevolence referred to the parental view toward the mentally ill and the feeling that they deserve kind treatment. The second study hypothesis stated that there was a statistically significant difference between the attitudes of MSWs and MHSWs toward mental illness on the Benevolence factor. This hypothesis was not rejected (refer to Tables 3.4b and 3.8).

Overall, MSWs scored higher, while MHSWs scored lower on survey items in the Benevolence dimension (refer to Table 3.4b). These MSWs would be more likely to act towards the mentally ill in a more paternal, yet charitable manner, as compared to MHSWs. This finding could be viewed as negative. When interacting with patients, this view may have hindered a patient's acceptance of responsibility for personal affairs and thus, retard self-sufficiency. Especially since mental patients would be regarded as children. This finding suggested that since MSWs consider mental illness as a disease, they may have catered to patients on the assumption that since they have a disease, they were poor unfortunates. This assumption may tend to foster dependency of the patient on the social worker and significant others such as relatives and friends.

This may occur because of the parental role of the social worker with respect to the patient. The social
worker may not have encouraged the patient to accept responsibility for personal affairs. For example, they may not handle such tasks as finances and shopping. The social worker may have delegated these tasks to a caseworker or relative, even though the patient would have been capable of accomplishing these tasks if given some guidance. Moreover, the patient may have been regarded as a charity case. Operating on the belief that such a person was unable to govern his/her personal tasks, this individual may be viewed as not capable of securing and maintaining employment. With this view, the social worker would not encourage the patient to seek employment.

Furthermore, these social workers may have felt that receiving public welfare would be sufficient rather than permitting him/her to earn some income. This may be in addition to or a substitute for public aid. This view has the potential for keeping mental patients in a sick role. The patient would not have known how to function alone, making recovery less likely.

Being trained from a different perspective, MHSWs may be less inclined to hold these beliefs than MSWs. The MHSWs may have felt that patients should demonstrate more responsibility, since their training was blame oriented. This attitude could have positive and negative outcomes.

For example, on the positive side, the patient may be allowed to assume greater responsibility for personal tasks and earning some finances. By doing so, s/he may gain self-
esteem. S/he would then view him/herself and be viewed by others as 'normal', since 'normal' persons govern their own affairs. In this respect, rehabilitation may be more likely to occur as the patient assumes the same tasks as 'normal' persons, thus increasing chances of recovery.

On the negative side, the social worker may prescribe more responsibility, such as performing personal duties, to a patient that was not capable of accomplishing these tasks. With failure, the patient may be reluctant to attempt any duties in the future. Self-confidence may then be substantially lowered. Such a setback could then hinder the patient's rehabilitation and limit the potential for improvement.

Both MSWs and MHSWs disagreed with Item #36, which stated that every mental hospital should be surrounded by a high fence and guards. This could be seen as positive. For example, both groups of social workers recognized that mental hospitals should not resemble prisons. A hospital's structure and surroundings may influence patient recovery. For example, high fences and the presence of guards would convey a feeling of mistrust and fear among patients. This may inhibit change; the patient may begin to feel as though s/he was indeed in prison and had done something wrong.

The majority of MSWs and MHSWs reported that they were trained in a public hospital (see Table 3.0b), at least 10 years ago. Such hospitals may indeed have had psychiatric units with such an appearance. Therefore, it is positive
that such structures and settings are no longer seen as desirable by these social workers. They may have responded to such a setting, therefore, they may have treated patients as if their illness was caused by abnormal behavior and their confinement was for a crime.

With such an atmosphere, patients may not improve, because they would tend to feel that they were being punished. The setting would also have fostered this feeling. In turn, they may have experienced both guilt and despair. They would tend not to be motivated to improve, thus lowering the probability of improvement.

MSWs and MHSWs appeared to have different scores on several survey items on this dimension. For example, Item #26 (see Table 3.4a) stated that people who have been patients in a mental hospital will never be themselves again. For MSWs to have disagreed with this statement was expected since they tend to view mental illness as a disease. Many MSWs may have felt that mental illness was curable. Therefore, patients have the potential to be restored to 'normal' functioning. In consequence, this finding can be perceived as positive. These MSWs may be more optimistic concerning a patient's rehabilitation. This attitude may be more apt to aid the patient, may help patient prognosis, resulting in recovery.

For MHSWs to have agreed with this statement was not surprising. Since their perspective was blame oriented, these MHSWs may have believed that the patient was
responsible for the illness, and desired to remain in this
dysfunctional condition. Thus the social worker would be
less apt to aid the patient in recovery. Therefore, this
view could be seen as negative. For example, these MHSWs
may be more pessimistic regarding a patient's prognosis,
thereby hindering rehabilitation and recovery.

Another survey item of interest was Item #37 (see Table
3.4a). This item stated that the law should allow a woman
to divorce her husband as soon as he has been confined in a
mental hospital with a severe mental illness. For MSWs to
have disagreed with this statement was expected. From the
MSW perspective, mental illness is a treatable disease.
Therefore, it is expected that the patient could be restored
to 'normal' functioning. Hence, a divorce by the wife of a
mentally ill husband would have been unnecessary.

This finding could be considered positive. These MSWs
may actually encounter such a situation. They may be asked
by wives for their opinions and convey to the wife that
mental illness can be treated. Therefore it would be
implusive or inappropriate for her to file for divorce.
Moreover, such an action may cause the husband to
decompenstate further since he would be losing a significant
other at a time when emotional support is crucial. Hence,
the patient may not reach his potential for recovery.

For MHSWs to have agreed with this statement was not
expected. This finding can perhaps be explained in terms of
Scheff's (1984) labeling theory. According to Scheff
(1984), a person is labeled deviant when s/he does not conform to the rules of society. Thus s/he violates societal norms. Mental illness is considered deviance, because its presence violates the implicit rule of maintaining decency and reality in the social order.

These MHSWs may thus have felt that since this man had been labeled mentally ill, and therefore deviant, divorce would be justified. The wife may not have wanted to remain married to someone in such a role, a role which may be perpetuated permanently. Since marriage is supposed to be forever, the woman may have been married to a mentally ill deviant person for the rest of her life. These MHSWs could have been identifying with this woman. This seems plausible since the majority of MSWs and MHSWs were female, and the majority of MHSWs were divorced or widowed (see Tables 3.1a, 3.1b, and 3.2b).

This finding could be seen as negative. As stated previously, if social workers encouraged divorce at this time, it could have devastating effects on the husband. For example, his condition would be worsened. Also, the husband may feel less motivated to recover, decreasing his chances of improvement.

On the Benevolence dimension, MSWs tended to believe that mental patients should be treated in a paternalistic and charitable manner, as compared to MHSWs. This result may have been acquired because MSWs tend to consider mental illness as a disease. Hence, they may cater to these
patients on the assumption that since they have a disease, then they were poor unfortunates.

However, such an attitude could be viewed as negative, because it may promote patient dependency towards the social worker and significant others. The tendency would be to treat the patient as a child. Thus s/he would not be allowed to assume responsibility for some personal tasks and earning finances, even if s/he was capable of doing so. This could be detrimental, because it would maintain the patient in a sick role, and his/her condition may not improve.

On the other hand, results showed these MHSWs were less paternal and charitable toward the mentally ill. This view could have positive and negative results. Since, the patient may carry out personal tasks as would 'normal' persons, this would enhance his/her self-esteem, thus helping the patient to recover.

From a negative perspective, there are patients that may not be capable of performing these duties. If such patients fail at tasks that are unrealistic for them, this failure may cause them to cease participation in any activities that would improve social functioning. This should be considered in the treatment plan. Therefore, the patient's chance for recovery may be limited. It may be advisable that the social worker assign tasks to patients that are realistic at that time in the treatment regimen.
**Mental Hygiene Ideology**

Mental Hygiene Ideology described the view that the mentally ill are similar to 'normal' individuals and mental illness is similar to any medical illness. The third study hypothesis stated that there was a statistically significant difference between the attitudes of MSWs and MHSWs toward mental illness on the Mental Hygiene Ideology factor. This hypothesis was not rejected (refer to Tables 3.5b and 3.8).

MSWs scored higher, while MHSWs scored lower on survey items in the Mental Hygiene Ideology dimension (refer to Table 3.7b). This finding can be seen as positive since these MSWs would tend to view patients as similar to 'normal' persons, thus considering mental illness as any medical illness. Since, they have perceived mental illness as a disease, the patient may be regarded as any other medical patient.

With this perspective, the social worker would tend to treat the patient as someone that is like medical patients, rather than as an inferior person with a disgraceful illness. This view toward mental patients would be helpful to the patient's recovery because s/he would be regarded in the same way as a 'normal' person.

Therefore, the patient would not not feel stigmatized because s/he was receiving treatment. In turn, the patient's self-esteem and inner strength may not be hindered. This would also be helpful in the rehabilitative process and provide a good opportunity for recovery. It
appears MSWs concern for the physical self may dominate the treatment arena as compared to MHSWs who were more affectively oriented.

Being trained from a blame oriented perspective, these MHSWs may view the patient as inferior and shameful. This finding could be seen as negative. However, it was expected, since MHSWs tend to be more involved with the affective domain than are MSWs. In so doing, patients may be more inclined to be influenced by diagnostic stereotyping, thus decreasing the possibility of patient rehabilitation and recovery.

Atwood (1982) stated that clinicians tend to stereotype patients depending on the patient diagnoses. Patients may thus be regarded more in terms of the stereotype that the diagnosis represents, and may judge the patient on this basis. For example, someone that has been diagnosed as schizophrenic would tend to be associated with certain behaviors such as hallucinations, delusional thinking, and impaired judgment. Therefore, whenever social workers encounter such patient, these characteristics may be associated with the patient, even though s/he may be in remission. This would then be detrimental for the patient. For example, the MHSWs would perceive the patient with regards to these diagnostic characteristics. Even though the person may be asymptomatic, the patient would be maintained in a sick role, with severely decreased chances of recovery.
MSWs and MHSWs appeared to have agreed with Item #Three. This item stated that most patients in mental hospitals were not dangerous. This finding was not surprising. For example, the majority of these MSWs and MHSWs had at least 10 years of experience in social work (see Tables 3.2a and 3.2b). Therefore, they were probably aware that society considers mental patients a danger to others.

However, it appears that these MSWs and MHSWs may have been less influenced by this stereotypical view. The typical 10 years of experience in treating mental patients, may have meant that they learned most mental patients are no more dangerous than 'normal' persons.

This finding can be viewed as positive, since these social workers may be less prone to exhibit fear when interacting with these patients. For example, if the patient is not regarded as dangerous, s/he would be more apt to sit closer and appear comfortable with the patient. In turn, such behavior could then convey to the patient that s/he is regarded as any other medical patient, rather than as someone that is alien and deviant. With this view, the patient may begin to see him/herself as similar to others. This could increase chances for improvement.

MSWs and MHSWs appeared to have different scores on several survey items, such as Item #23 (see Table 3.5a). This item stated that if hospitals had enough well trained doctors, nurses, and aides, many of the patients would get
well enough to live outside the hospital. For MSWs to have agreed with this statement was expected.

Believing that mental illness was a disease, they may have felt that with more well trained staff this disease could be stabilized. This would allow patients to function in the community as compared to remaining in the hospital. This finding could be perceived as positive, because the recidivism rates of these patients could then be reduced.

For MHSWs to have disagreed with this statement was not surprising. Believing that mental illness was in some way motivated by the patient, MHSWs may have felt that despite a well trained staff, the patient may desire to remain in this condition.

This finding could be seen as negative, because social workers would be placing blame on the patient for the illness when other factors may have contributed to this dysfunctional condition. Thus, treatment could be less effective. For example, these contributory factors may not have been considered when developing a treatment plan. Therefore, the treatment plan may be inappropriate for the patient. This could decrease the probability that the patient would improve.

Another survey item that MSWs and MHSWs had different scores on in this dimension was Item #44 (see Table 3.5a). This item stated that many people who had never been patients in a mental hospital were more mentally ill than many hospitalized mental patients. For MSWs to have agreed
with this statement was expected. Since they considered mental illness as a disease, these MSWs may have believed that there were some persons incapable of seeking help because of this disease.

Also, such persons may be in a predicament in which they cannot receive treatment. The evidence of this phenomena may be manifested with the homeless mentally ill. This finding may be viewed as positive, since such a realization may prompt these social workers to campaign for more services for the homeless mentally ill. Moreover, clinical settings of these social workers may provide outreach programs for these persons. Through these programs, mental health professionals could visit shelters to identify, diagnose, and treat mentally ill persons. In so doing, the patient would have a greater chance for recovery, since s/he would be receiving treatment. MHSWs tended to have disagreed with this statement. However, such a finding cannot be explained. Thus, implications for patient care are not known with regard to this item.

Another survey item that MSWs and MHSWs had different scores on was Item #50. This item stated that many mental patients would remain in the hospital until they were well, even if the doors were unlocked. For MSWs to have disagreed with this statement was surprising since it was expected that MSWs would have agreed. For example, MSWs may tend to view patients from the disease model. Thus they tend to consider mental patients as any other medical patient and
may have reasoned that because medical patients usually remain in the hospital until recovery mental patients should do likewise.

Since MSWs are more cognitively oriented, they may have believed that mental patients lack the cognitive ability to understand that it would be best to stay hospitalized until recovery. In such a situation, the social worker could encourage these patients to remain in the hospital until stabilized, to increase the patient's chances for recovery. MHSWs tended to have agreed with this statement. Again, this finding cannot be explained. Thus, implications for patient care are not known with regard to this item.

On the Mental Hygiene Ideology dimension, MSWs tended to perceive the mentally ill as similar to 'normal' persons. It appears that they considered mental illness as similar to any medical illness as compared to MHSWs. This is a positive finding as it relates to MSWs. For example, MSWs appear to be less inclined to stereotype or stigmatize mental patients. In the treatment regimen, the patient may be treated the same as any 'normal' patient. This may result in a better chance for the patient's return to 'normal' functioning.

However, for MHSWs, this attitude may have negative affects for the patient. This attitude may hinder the rehabilitation process because the MHSWs appear to have believed that the patient was inferior to others. Thus mental illness was seen as an alien disease. With this
view, the MHSWs may tend to stigmatize or stereotype the patient. In turn, this could reduce the patient's self-confidence and cause him/her to view him/herself as different. Hence, patients may not strive to fulfill their potential. This could lessen the opportunity for improvement.

**Social Restrictiveness**

Social Restrictiveness referred to the view that the mentally ill are menaces to society, and that restrictions should be placed on them during and after hospitalization. The fourth study hypothesis stated that there was a statistically significant difference between the attitudes of MSWs and MHSWs toward mental illness on the Social Restrictiveness factor. This hypothesis was not rejected (Refer to Table 3.6b and 3.8).

MSWs scored higher, while MHSWs scored lower on the Social Restrictiveness dimension (refer to Table 3.6b). Therefore, these MSWs considered the mentally ill as menaces to others and felt that there should have been physical and social restrictions placed on them.

This finding could be regarded as negative, because a social worker with such an attitude may convey this (probably nonverbally) to the patient. For example, s/he may physically distance him/herself by not sitting close to the patient. S/he may also appear nervous when in the presence of the patient regarding physical safety. Even though the social worker may attempt to appear comfortable,
the patient may sense that the social worker feels threatened by the patient.

Hence, the relationship would be impaired, since both the social worker and patient would not feel comfortable with each other. Therefore, trust between them may not develop. Even though trust is essential in the therapeutic process; thus, it may decrease the probability that treatment would be effective. In turn, this could reduce the chances that the patient would recover.

If MSWs considered the patient as a threat, certain restrictions may then be encouraged. In a hospital, such restrictions could be locked doors and units. Patients may also be given few privileges in such an environment. Upon returning to the community, perhaps limited encouragement would be given for patients to perform in 'normal' activities. This may further separate such an individual from society, and cause the former patient to recidivate.

This restrictive view parallels Scheff's (1984) theory. As Scheff (1984) discussed, the patient may face restrictions when seeking employment because of a psychiatric history, even though s/he is asymptomatic. This would tend to result in maintaining this person in a sick role such that his/her probability of recovery is low and recidivism is perhaps high.

These MHSWs may have scored low on Social Restrictiveness as compared to MSWs, since they regard mental illness as a result of the patient's actions. They
may have felt that patients were not dangerous and since this condition was in some way caused by the patient, s/he may have some control over it. Thus, there would be no threat to others. Further, there would be no need for physical restrictions on patients.

This finding may be considered positive. For example, these social workers may tend to encourage mental patients to become involved in social activities which may serve to integrate them more into society. By doing so, such patients may not perceive themselves as subordinate to others. This may prompt a change from the sick role to one of wellness. This may aid in the improvement of the patient.

MSWs and MHSWs appeared to have disagreed with Item #42 (see Table 3.6a). This item stated that most patients in mental hospitals did not care how they looked. This finding suggests that these social workers may have realized that even though someone has a mental illness, they may still retain interest in their appearance.

The majority of these MSWs and MHSWs had at least 10 years of experience in social work (see Tables 3.2a and 3.2b). Therefore, they were probably aware that society regards mental patients as dirty and unattractive. However, it appears that these MSWs and MHSWs may have been less influenced by this stereotypical view. With at least 10 years of experience, inclusive of treating mental patients,
they may have learned that most mental patients do care about their appearance.

This finding can be viewed as positive, because such attitudes may mean these social workers tend to encourage patients to improve their appearance. This may have therapeutic value, because the patient may show more interest in grooming, thus improving self-image. Also, society may receive discharged patients better if their appearances reflect good grooming, thus making it easier for these patients to blend in with others in society, and maintain recovery.

MSWs and MHSWs had different scores on Item #41. This item stated that most women who were once patients in a mental hospital could not be trusted as babysitters. For MSWs to have agreed with this statement was surprising. From their perspective, mental illness is a treatable disease. Hence, there would have been no danger that these patients would harm children since recovery is a real possibility.

This finding could be perceived as negative, since such restrictive views may hinder a patient from employment, and serve only to isolate them from others in society. This would help to maintain patients with diminished chances for recovery.

For MHSWs to have disagreed with this statement was expected. From their perspective, patients can be trusted since at some point their behavior or condition can
eventually be changed if that change is desirable. Therefore, the social worker may have felt that it would be safe for most patients to care for children.

This finding may be regarded as positive, because these social workers believed that some mental patients can be trusted to perform certain jobs that require high levels of trust. With such a belief, these social workers may tend to encourage patients to seek job opportunities. In turn, this would promote recovery because ex-patients would be performing tasks as 'normals'. Hence, patients may eventually accept a healthier role and thus, facilitate recovery.

On the Social Restrictiveness dimension, MSWs tended to have considered the mentally ill as menaces to others as compared to MHSWs. They also appear to have felt that physical and social restrictions should be imposed on mental patients during and after hospitalization, more than MHSWs. This finding could be viewed as counterproductive. For example, the social worker may not encourage patients to participate in activities as s/he would 'normal' persons. This would result in maintaining the patient in a separate and inferior status, further perpetuating the sick role and decreasing the chances of improvement/recovery. As mentioned, when compared to MSWs, MHSWs held less socially restrictive views toward the mentally ill. This may be perceived as positive since patients may be prompted to get involved in 'normal' activities. Patients may tend to view
themselves in a healthier role. Improvement/recovery would be more highly probable.

**Interpersonal Etiology**

Interpersonal Etiology referred to the belief that mental illness is the result of poor interpersonal relationships, namely lack of parental concern during the childhood years. The fifth study hypothesis stated that there was a statistically significant difference between the attitudes of MSWs and MHSWs toward mental illness on the Interpersonal Etiology factor. This hypothesis was not rejected (Refer to Tables 3.7b and 3.8).

MSWs scored higher, while MHSWs scored lower on survey items in the Interpersonal Etiology dimension. It seems that these MSWs believed that mental illness was caused by poor interpersonal experiences, namely lack of parental concern during the childhood years.

This finding suggests that these MSWs may have been exposed through education and/or training to Freudian theory reflective of the deprivation theory that assumes people become mentally ill to avoid difficult problems.

This finding was not expected since MSWs are trained from a disease model perspective. This attitude can negatively affect patient care. For example, MSWs may rely on both models to create their treatment plan, rather than solely subscribing to the disease model. However, this finding may be seen as positive. For example, if both models are utilized additional contributory factors may be
considered. This could give social workers greater insight into the source(s) of patient dysfunction. With this information, a more appropriate plan may be designed that would result in making recovery more highly probable for patients.

These MHSWs may have scored lesser on Interpersonal Etiology since they have adhered to the belief that an individual's own behaviors or actions have contributed to mental illness rather than the impact of poor interpersonal experiences. This finding was surprising. It was expected that these MHSWs would have scored greater on the Interpersonal Etiology dimension. Since the majority of MHSWs had at least 10 years of experience in mental health social work, they were probably aware that mental illness can emerge from various sources in a person's life. These sources could be physical, social, or financial and psychological.

MHSWs may be more accustomed to placing blame on the patient for his/her illness. Therefore, they may not want to consider the idea that other factors may have caused mental illness. Since this would take the fault from the patient and place the blame on other variables. This would be opposed to this social worker's diagnostic orientation and may make the social worker hesitant to consider another theoretical approach after adhering to the blame oriented perspective. For example, as mentioned earlier, the impact that several sources may have on the patient's condition may
not be regarded. Hence, the influence of these sources on the patient would not be considered. Consequently, patients' recovery may be impeded since these influences may not be examined.

MSWs and MHSWs disagreed with Item #20. This item stated that mental patients came from homes where the parents took little interest in their children. For MSWs to have disagreed with this statement was not surprising. This finding could be perceived as positive.

Even though some of these MSWs adhere to some principles in Freudian theory, disagreeing with this statement shows that they recognized that there may be many factors that contribute to the onset of mental illness. Therefore, this finding can be viewed as positive.

While there may be incidences in which this statement holds true, this should not be construed as an absolute. With this view, these social workers may regard other factors as causing the patient's illness also. This may also result in a more effective treatment, since the social worker would be aware of additional sources that could encompass patients' social environment. Such sources could be taken into consideration when treating the patient, thus providing more effective treatment. Consequently, this may lead to patients' more timely and probable recovery.

For MHSWs to have disagreed with this statement was expected, because such an attitude is opposed to the blame oriented perspective. In this case, neither model employed
solely would assist the social worker in understanding the true source of patients' mental illness.

The blame oriented model concentrates primarily on the patient's actions as an indicator of the cause of the illness. Also, Freudian theory tends to disregard the impact that forces, other than interpersonal experiences have on the patient. However, patients may not receive appropriate treatment if the social worker utilizes one of these models solely, because certain influences may not have been viewed, when they actually had significance. Therefore, that issue would not be addressed, resulting in an inappropriate treatment regimen, with more minimal chance for patients' recovery.

MSWs and MHSWs had different scores on Item #10. This item stated that although they usually were not aware of it, many people become mentally ill to avoid the difficult problems of everyday life.

For MSWs to have agreed with this statement was surprising. However, as mentioned earlier, they may have adopted attitudes through education and/or training, which caused them to accept some Freudian principles.

This finding may be seen as positive, because the social worker may consider additional factors in the onset of the patient's illness in conjunction with other possibilities. In this way, the social worker may feel more assured that s/he has a comprensive view of the patient.

This may help the social worker in determining the
appropriate treatment. This may increase the possibility that the patient will recover.

For MHSWs to have disagreed with this statement was not expected. The blame oriented perspective, places the blame for this illness on the sick individual. Therefore, it was expected that these MHSWs would have agreed with this statement. This finding could not be explained and implications for patient care are not known with regard to this item.

On the Interpersonal Etiology dimension, MSWs tended to believe that mental illness was the result of poor interpersonal relationships, such as lack of parental concern during the childhood years, as compared to MHSWs. This could be regarded as positive. For example, if these Freudian principles are employed in concert with the disease model, social workers could have a more comprehensive view of the patient. Therefore s/he may be able to plan treatments that would better target the patients' problem, and thereby improve patients' chance for recovery.

That MHSWs may tend to agree less with Freudian theory cannot be fully explained. However, it can be offered that social workers may be less inclined to divert from the blame oriented perspective. Such a diversion would force them to examine the influence of other variables in causing mental illness. Impacts on patient care can be viewed as negative if the MHSW relies only on the blame oriented perspective. For example, the social worker would be primarily concerned
with the patient's role in causing his/her illness, while other circumstances were not considered or were ignored. Therefore, the patient's chance for recovery may be hindered since the treatment plan employed may not focus on significant causal factors.

**Summary/Conclusions**

On the dimensions in which there were differences in scores of medical social workers (MSWs) as compared to mental health social workers (MHSWs), it does not appear they could be attributed to sample characteristics. For example, both samples were basically alike when demographic data were considered. Although, the majority of MHSWs reported a slightly higher income and were divorced or widowed (see Table 3.2b). Therefore, it is more likely that scores of MSWs as compared to MHSWs were influenced by occupation as compared to demographic differences.

It may be that MSWs and MHSWs had similar scores on Authoritarianism since Black females have had roles which were nonauthoritarian. Consequently, they may be less inclined to hold authoritarian attitudes. However, on the remaining dimensions, Benevolence, Mental Hygiene Ideology, Social Restrictiveness and Interpersonal Etiology, score differentials may be due to these social workers being trained from different theoretical perspectives concerning the mentally ill.

Although the sample that was desired for inclusion in this study was obtained, outcomes could have been affected
by the imbalance between MSWs and MHSWs in the sample. For example, there were more MSWs represented in the study than MHSWs.

Fortunately, the sample was mature, educated, and well experienced in the field of social work. Consequently, the findings of this study appear to be relatively unbiased. It is assumed that data reflected real attitudes rather than ideal attitudes.

The focus of this study was attitudinal research. As suggested by the literature, social workers' attitudes toward mental illness can have a positive or negative influence on the therapeutic relationship between the social worker and patient. In turn, these attitudes tend to profoundly affect the patient's chances for recovery.

As discussed earlier, attitudes can have as much of an impact on patient care as therapeutic techniques. In the same way that inappropriate therapeutic techniques can result in ineffective treatment, negative attitudes can have a similar effect on patient improvement and recovery. Therefore, it is hoped that this study will serve as an impetus for renewed interest in social workers examining their attitudes toward mental illness.
Implications For Patient Care

When attitudinal results were examined, the implications they have for patient care are recognized.

The administrator/director of any settings in which patients receive such care should devise a plan that would increase social workers' attitudes that reflected low levels of authoritarianism.

Also, social workers should encourage patients toward independence, rather than being treated like children, which may cause patients to become dependent on others.

Social workers should treat mental patients similar to medical patients, so that the patients will not feel stigmatized.

In addition, in a clinical setting, the environment should be less physically and socially restrictive so that the patient would not feel as though s/he was in prison and had committed a crime. Further, social workers should prompt patients to participate in 'normal' activities.

Patients are usually hospitalized or on a caseload for no more than 30 days, therefore, long term psychotherapy may not be feasible. For example, social workers that rely on Freudian theory, concentrate on issues that occurred during childhood, and it may take long term psychotherapy to uncover these causal factors. Therefore, a short term treatment approach may be more appropriate because of time constraints.
An administrator/director of a clinical setting may have an indication that some social workers on staff held attitudes that may have a negative impact on patients' progress. This may occur when complaints are received from staff members, patients and/or their significant others. Another indication would be that patients were not progressing as expected, and/or recidivism had increased.

At this point, the administrator/director should investigate these occurrences, to determine possible causes. One of the strategies utilized should be to assess social workers' attitudes toward mental illness.

The administrator/director could then administer the Opinions About Mental Illness Scale to these social workers, under conditions in which anonymity could be maintained. This approach may be more feasible since social workers may be reluctant to disclose their true attitudes during open discussions at staff meetings.

After the survey results are interpreted, seminars could then be planned which focused on the negative consequences of these attitudes. These seminars could include lectures, discussion and the distribution of literature on mental illness, which debunks some of these stereotypical views. In addition, role-playing could take place, so that the social workers could witness the impact that such views could have on the therapeutic relationship. This would then demonstrate the need to change these
attitudes, since such an influence may limit patient recovery.

Through these seminars, the administrator/director could also offer alternatives to the theoretical models utilized by MSWs and MHSWs. These alternatives should be employed in conjunction with the present model being utilized at the setting. The alternative models should consider the role that other sources in a patient's social environment may have upon his/her illness. These contributory factors would be significant, since they should be considered, when developing a treatment plan so that the optimum opportunity for patient recovery is created.

Implications For Social Work/Social Work Training

As mentioned earlier, it may be assumed that MSWs are trained from the disease model and MHSWs are trained from the blame oriented perspective. Each model has its merits in assessing patients, but there are disadvantages. For example, each model tends to disregard the impact that other sources may have upon an individual. Training social workers and social work students should emphasize utilizing a treatment model that includes such a component.

Social workers should also be taught the impact their attitudes toward mental illness may have on patient care. For social workers, there should be ongoing training at their respective clinical settings. In addition, MSWs and MHSWs could rotate assignments so that this exposure to
different perspectives could create a more effective diagnostic and treatment orientation.

For social work students, it is recommended that practicums be assigned on both medical and psychiatric units so that the student would also receive exposure to these differential theoretical models. The clinical methods course could include theoretical approaches that consider a person's social environment and other sources from which there may be significant causal factors.

Implications For Future Research

When future research is considered, social workers' attitudes toward mental illness should be examined, with regard to typical patient profile for particular settings. Another potential study could involve the settings in which social workers are employed, to determine if the type of setting has an impact on social workers' attitudes. Attitudes of social workers in other fields, such as public welfare, public health, and industrial social work should be of interest to future researchers. For example, they too may have recovering or former mental patients on their caseload. Therefore, their attitudes may also influence the quality of services provided to patients, thus impacting patient care.
References


Appendix A

Form 1

Section A

OPINIONS ABOUT MENTAL ILLNESS SURVEY

Instructions: Listed below are some questions that describe you (Section A). The next section (Section B) contains statements designed to elicit your opinions about mental illness. Feel free to respond since all answers are held in the strictest of confidence. Please answer all questions simply by placing a check ( ) next to the appropriate response.

1. Race  
   __  1. Black  
   ___  2. White

2. Gender  
   ___  1. Female  
   ___  2. Male

3. Age  
   ___  1. under 20 
   ___  2. 21 - 25 
   ___  3. 26 - 29 
   ___  4. 30 - 34 
   ___  5. 35 - 39 
   ___  6. 40 - 44 
   ___  7. 45 - 49 
   ___  8. 50 +

4. Highest Level of Education Achieved  
   ___  1. BA/BS degree 
   ___  2. BSW degree 
   ___  3. MA/MS degree 
   ___  4. MSW degree 
   ___  5. EdD/PhD degree

5. Marital Status  
   ___  1. Single 
   ___  2. Married 
   ___  3. Separated 
   ___  4. Divorced/Widowed

6. Income Status  
   ___  0. no income 
   ___  1. $1-4,999 
   ___  2. $5,000-9,999 
   ___  3. $10,000-14,999 
   ___  4. $15,000-19,999 
   ___  5. $20,000-24,999 
   ___  6. $25,000-29,999 
   ___  7. $30,000-34,999 
   ___  8. $35,000-39,999 
   ___  9. $40,000 +
Appendix A (Continued)

7. Setting In Which Trained
   ___ 1. public hospital
   ___ 2. private hospital
   ___ 3. community mental health center
   ___ 4. public mental hospital
   ___ 5. private mental hospital

8. Years of Experience In Medical Social Work
   ___ 1. less than 1 year
   ___ 2. 1 - 3 years
   ___ 3. 4 - 6 years
   ___ 4. 7 - 10 years
   ___ 5. 10 - 15 years
   ___ 6. 15 - 20 years
   ___ 7. 20+ years
Appendix A (Continued)

Form 2
Section A

OPINIONS ABOUT MENTAL ILLNESS SURVEY

Instructions: Listed below are some questions that describe you (Section A). The next section (Section B) contains statements designed to elicit your opinions about mental illness. Feel free to respond since all answers are held in the strictest of confidence. Please answer all questions simply by placing a check ( ) next to the appropriate response.

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Race</td>
<td></td>
<td>2. Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Black</td>
<td></td>
<td>1. Female</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. White</td>
<td></td>
<td>2. Male</td>
<td></td>
</tr>
<tr>
<td>3. Age</td>
<td></td>
<td>4. Highest Level of Education Achieved</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. under 20</td>
<td></td>
<td>1. BA/BS degree</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. 21 - 25</td>
<td></td>
<td>2. BSW degree</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. 26 - 29</td>
<td></td>
<td>3. MA/MS degree</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. 30 - 34</td>
<td></td>
<td>4. MSW degree</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. 35 - 39</td>
<td></td>
<td>5. EdD/PhD degree</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. 40 - 44</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7. 45 - 49</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8. 50 +</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Marital Status</td>
<td></td>
<td>6. Income Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Single</td>
<td></td>
<td>0. no income</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Married</td>
<td></td>
<td>1. $1-4,999</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Separated</td>
<td></td>
<td>2. $5,000-9,999</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Divorced/Widowed</td>
<td></td>
<td>3. $10,000-14,999</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4. $15,000-19,999</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5. $20,000-24,999</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>6. $25,000-29,999</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>7. $30,000-34,999</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>8. $35,000-39,999</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>9. $40,000 +</td>
<td></td>
</tr>
</tbody>
</table>
Appendix A (Continued)

7. Setting In Which Trained
   ___ 1. public hospital
   ___ 2. private hospital
   ___ 3. community mental health center
   ___ 4. public mental hospital
   ___ 5. private mental hospital

8. Years of Experience In Medical Social Work
   ___ 1. less than 1 year
   ___ 2. 1 - 3 years
   ___ 3. 4 - 6 years
   ___ 4. 7 - 10 years
   ___ 5. 10 - 15 years
   ___ 6. 15 - 20 years
   ___ 7. 20+ years
The statements that follow are opinions or ideas about mental illness and mental patients. By mental illness, we mean the kinds of illness which bring patients to mental hospitals, and by mental patients we mean mental hospital patients. There are many differences of opinion about this subject. In other words, many people agree with each of the following statements while many people disagree with each of these statements. We would like to know what you think about these statements. Each of them is followed by four choices, please indicate whether you strongly disagree (SD), disagree (D), agree (A), or strongly agree (SA).

Please check () in the space provided that choice which comes closest to saying how you feel about each statement. You can be sure that many people, including doctors, will agree with your choice. There are no right or wrong answers: we are only interested in your opinion. It is very important that you answer every item.

1. NERVOUS BREAKDOWNS USUALLY RESULT WHEN PEOPLE WORK TOO HARD.

<table>
<thead>
<tr>
<th></th>
<th>SD</th>
<th>D</th>
<th>A</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>()</td>
<td>()</td>
<td>()</td>
<td>()</td>
</tr>
</tbody>
</table>

2. MENTAL ILLNESS IS AN ILLNESS LIKE ANY OTHER.

<table>
<thead>
<tr>
<th></th>
<th>SD</th>
<th>D</th>
<th>A</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>()</td>
<td>()</td>
<td>()</td>
<td>()</td>
</tr>
</tbody>
</table>

3. MOST PATIENTS IN MENTAL HOSPITALS ARE NOT DANGEROUS.

<table>
<thead>
<tr>
<th></th>
<th>SD</th>
<th>D</th>
<th>A</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>()</td>
<td>()</td>
<td>()</td>
<td>()</td>
</tr>
</tbody>
</table>
Appendix A (Continued)

4. ALTHOUGH PATIENTS DISCHARGED FROM MENTAL HOSPITALS MAY
SEEM ALL RIGHT, THEY SHOULD NOT BE ALLOWED TO MARRY.

SD D A SA
1 2 3 4
() () () ()

5. IF PARENTS LOVED THEIR CHILDREN MORE, THERE WOULD BE
LESS MENTAL ILLNESS.

SD D A SA
1 2 3 4
() () () ()

6. IT IS EASY TO RECOGNIZE SOMEONE WHO ONCE HAD A SERIOUS
MENTAL ILLNESS.

SD D A SA
1 2 3 4
() () () ()

7. PEOPLE WHO ARE MENTALLY ILL LET THEIR EMOTIONS CONTROL
THEM; NORMAL PEOPLE THINK THINGS OUT.

SD D A SA
1 2 3 4
() () () ()

8. PEOPLE WHO WERE ONCE PATIENTS IN MENTAL HOSPITALS ARE
NO MORE DANGEROUS THAN THE AVERAGE CITIZEN.

SD D A SA
1 2 3 4
() () () ()

9. WHEN A PERSON HAS A PROBLEM OR A WORRY, IT IS BEST NOT
TO THINK ABOUT IT, BUT KEEP BUSY WITH MORE PLEASANT
THINGS.

SD D A SA
1 2 3 4
() () () ()

10. ALTHOUGH THEY USUALLY ARE NOT AWARE OF IT, MANY PEOPLE
BECOME MENTALLY ILL TO AVOID THE DIFFICULT PROBLEMS OF
EVERYDAY LIFE.

SD D A SA
1 2 3 4
() () () ()
Appendix A (Continued)

11. THERE IS SOMETHING ABOUT MENTAL PATIENTS THAT MAKES IT EASY TO TELL THEM FROM NORMAL PEOPLE.

   SD  D  A  SA  
   1  2  3  4  
   ()  ()  ()  ()

12. EVEN THOUGH PATIENTS IN MENTAL HOSPITALS BEHAVE IN FUNNY WAYS, IT IS WRONG TO LAUGH AT THEM.

   SD  D  A  SA  
   1  2  3  4  
   ()  ()  ()  ()

13. MOST MENTAL PATIENTS ARE WILLING TO WORK.

   SD  D  A  SA  
   1  2  3  4  
   ()  ()  ()  ()

14. THE SMALL CHILDREN OF PATIENTS IN MENTAL HOSPITALS SHOULD NOT BE ALLOWED TO VISIT THEM.

   SD  D  A  SA  
   1  2  3  4  
   ()  ()  ()  ()

15. PEOPLE WHO ARE SUCCESSFUL IN THEIR WORK Seldom BECOME MENTALLY ILL.

   SD  D  A  SA  
   1  2  3  4  
   ()  ()  ()  ()

16. PEOPLE WOULD NOT BECOME MENTALLY ILL IF THEY AVOIDED BAD THOUGHTS.

   SD  D  A  SA  
   1  2  3  4  
   ()  ()  ()  ()

17. PATIENTS IN MENTAL HOSPITALS ARE IN MANY WAYS LIKE CHILDREN.

   SD  D  A  SA  
   1  2  3  4  
   ()  ()  ()  ()
Appendix A (Continued)

18. MORE TAX MONEY SHOULD BE SPENT IN THE CARE AND TREATMENT OF PEOPLE WITH SEVERE MENTAL ILLNESS.

SD D A SA
1 2 3 4
( ) ( ) ( )

19. A HEART PATIENT HAS JUST ONE THING WRONG WITH HIM/HER, WHILE A MENTALLY ILL PERSON IS COMPLETELY DIFFERENT FROM OTHER PATIENTS.

SD D A SA
1 2 3 4
( ) ( ) ( )

20. MENTAL PATIENTS COME FROM HOMES WHERE THE PARENTS TOOK LITTLE INTEREST IN THEIR CHILDREN.

SD D A SA
1 2 3 4
( ) ( ) ( )

21. PEOPLE WITH MENTAL ILLNESS SHOULD NEVER BE TREATED IN THE SAME HOSPITAL AS PEOPLE WITH PHYSICAL ILLNESS.

SD D A SA
1 2 3 4
( ) ( ) ( )

22. ANYONE WHO TRIES HARD TO BETTER HIM/HERSELF DESERVES THE RESPECT OF OTHERS.

SD D A SA
1 2 3 4
( ) ( ) ( )

23. IF OUR HOSPITALS HAD ENOUGH WELL TRAINED DOCTORS, NURSES, AND AIDES, MANY OF THE PATIENTS WOULD GET WELL ENOUGH TO LIVE OUTSIDE THE HOSPITAL.

SD D A SA
1 2 3 4
( ) ( ) ( )

24. A WOMAN WOULD BE FOOLISH TO MARRY A MAN WHO HAS HAD A SEVERE MENTAL ILLNESS, EVEN THOUGH HE SEEMS FULLY RECOVERED.

SD D A SA
1 2 3 4
( ) ( ) ( )

Appendix A (Continued)

25. IF THE CHILDREN OF MENTALLY ILL PARENTS WERE RAISED BY NORMAL PARENTS, THEY WOULD PROBABLY NOT BECOME MENTALLY ILL.

26. PEOPLE WHO HAVE BEEN PATIENTS IN A MENTAL HOSPITAL WILL NEVER BE THEMSELVES AGAIN.

27. MANY MENTAL PATIENTS ARE CAPABLE OF SKILLED LABOR, EVEN THOUGH IN SOME WAYS THEY ARE VERY DISTURBED MENTALLY.

28. OUR MENTAL HOSPITALS SEEM MORE LIKE PRISONS THAN LIKE PLACES WHERE MENTALLY ILL PEOPLE CAN BE CARED FOR.

29. ANYONE WHO IS IN A HOSPITAL FOR A MENTAL ILLNESS SHOULD NOT BE ALLOWED TO VOTE.

30. THE MENTAL ILLNESS OF MANY PEOPLE IS CAUSED BY THE SEPARATION OR DIVORCE OF THEIR PARENTS DURING CHILDHOOD.

31. THE BEST WAY TO HANDLE PATIENTS IN MENTAL HOSPITALS IS TO KEEP THEM BEHIND LOCKED DOORS.
Appendix A (Continued)

32. TO BECOME A PATIENT IN A MENTAL HOSPITAL IS TO BECOME A FAILURE IN LIFE.

33. THE PATIENTS OF MENTAL HOSPITALS SHOULD BE ALLOWED MORE PRIVACY.

34. IF A PATIENT IN A MENTAL HOSPITAL ATTACKS SOMEONE, S/HE SHOULD BE PUNISHED SO S/HE DOES NOT DO IT AGAIN.

35. IF THE CHILDREN OF NORMAL PARENTS WERE RAISED BY MENTALLY ILL PARENTS, THEY WOULD PROBABLY BECOME MENTALLY ILL.

36. EVERY MENTAL HOSPITAL SHOULD BE SURROUNDED BY A HIGH FENCE AND GUARDS.

37. THE LAW SHOULD ALLOW A WOMAN TO DIVORCE HER HUSBAND AS SOON AS HE HAS BEEN CONFINED IN A MENTAL HOSPITAL WITH A SEVERE MENTAL ILLNESS.

38. PEOPLE (BOTH VETERANS AND NON-VETERANS) WHO ARE UNABLE TO WORK BECAUSE OF MENTAL ILLNESS SHOULD RECEIVE MONEY FOR LIVING EXPENSES.
Appendix A (Continued)

39. MENTAL ILLNESS IS USUALLY CAUSED BY SOME DISEASE OF THE NERVOUS SYSTEM.

40. REGARDLESS OF HOW YOU LOOK AT IT, PATIENTS WITH SEVERE MENTAL ILLNESS ARE NO LONGER REALLY HUMAN.

41. MOST WOMEN WHO WERE ONCE PATIENTS IN A MENTAL HOSPITAL COULD BE TRUSTED AS BABY SITTERS.

42. MOST PATIENTS IN MENTAL HOSPITALS DO NOT CARE HOW THEY LOOK.

43. COLLEGE PROFESSORS ARE MORE LIKELY TO BECOME MENTALLY ILL THAN ARE BUSINESS MEN.

44. MANY PEOPLE WHO HAVE NEVER BEEN PATIENTS IN A MENTAL HOSPITAL ARE MORE MENTALLY ILL THAN MANY HOSPITALIZED MENTAL PATIENTS.

45. ALTHOUGH SOME MENTAL PATIENTS SEEM ALL RIGHT, IT IS DANGEROUS TO FORGET FOR A MOMENT THAT THEY ARE MENTALLY ILL.
Appendix A (Continued)

46. SOMETIMES MENTAL ILLNESS IS PUNISHMENT FOR BAD DEEDS.

47. OUR MENTAL HOSPITALS SHOULD BE ORGANIZED IN A WAY THAT MAKES THE PATIENT FEEL AS MUCH AS POSSIBLE LIKE S/HE IS LIVING AT HOME.

48. ONE OF THE MAIN CAUSES OF MENTAL ILLNESS IS A LACK OF MORAL STRENGTH OR WILL POWER.

49. THERE IS LITTLE THAT CAN BE DONE FOR PATIENTS IN A MENTAL HOSPITAL EXCEPT TO SEE THAT THEY ARE COMFORTABLE AND WELL FED.

50. MANY MENTAL PATIENTS WOULD REMAIN IN THE HOSPITAL UNTIL THEY ARE WELL, EVEN IF THE DOORS ARE UNLOCKED.

51. ALL PATIENTS IN MENTAL HOSPITALS SHOULD BE PREVENTED FROM HAVING CHILDREN BY A PAINLESS OPERATION.

PLEASE CHECK BACK AND MAKE SURE THAT YOU HAVE NOT LEFT OUT ANY STATEMENTS OR PAGES OF STATEMENTS.
Dear ____________________,

I want to thank you for allowing me to conduct a study involving your social work staff. The purpose of my study is to compare the attitudes of medical social workers and mental health social workers toward mental illness. This study is significant, since it has implications for patient care. The questionnaires will be administered and collected during the period of March 8 - March 22, 1989.

This letter is a follow-up to the phone conversation we had on ______________. The following summarizes the administrative agreements that were made.

On the part of ______________________________, to permit your social work staff to participate in this study by completing a questionnaire.

To provide days, times, and a room in which the social workers can meet to complete the questionnaire.

To inform social workers of the days, times, and place in which the study will be conducted.

On the part of Sandra E. Wilson, to come to the setting, and administer questionnaires to social workers on specific days, times, and in a designated room.

To collect the completed questionnaires.

To protect the anonymity of the setting and social workers.
Appendix B (Continued)

To give a report to the hospital 60 days after the dissertation is completed.
To reserve the right to publication.
Thank you for your cooperation in undertaking this study.

Sincerely,

Sandra E. Wilson