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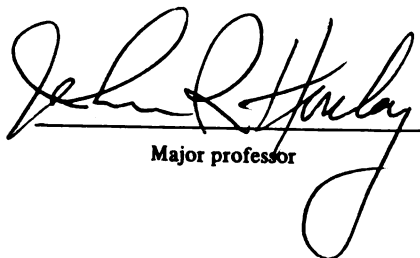
**Effects of Contacts with
Mental Health Professionals on
Mental Health Attitudes**

presented by

Ruth Ellen Euchner

has been accepted towards fulfillment
of the requirements for

Master's degree in Psychology


Major professor

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**EFFECTS OF CONTACTS WITH MENTAL HEALTH PROFESSIONALS
ON MENTAL HEALTH ATTITUDES**

By

Ruth Ellen Euchner

A THESIS

**Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of**

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ABSTRACT

EFFECTS OF CONTACTS WITH MENTAL HEALTH PROFESSIONALS ON MENTAL HEALTH ATTITUDES

By

Ruth Ellen Euchner

Research conducted over the last 30 years suggests that public attitudes toward mental health are quite stable. This study sought to assess the continued stability of such attitudes and also to ascertain if direct experience with mental health professionals influenced such attitudes. New data from 472 community college students were largely consistent with those of five earlier U.S. and New Zealand studies. Experience with mental health professionals did not significantly impact these attitudes with two notable exceptions: (a) respondents who indicated family or friends had received professional help rated "insane person" more favorably than did others, and (b) respondents indicating satisfaction with the professional help that they received rated "psychologist" more favorably than dissatisfied respondents. The results confirm the stability of public attitudes toward mental health, but appear to suggest that psychological practitioners may play a unique role in the restructuring of these attitudes.

To my parents, my friends, and, of course, Cady and Idgie.

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CHAPTER ONE

INTRODUCTION AND LITERATURE REVIEW

In his 1961 book Popular Conceptions of Mental Health: Their Development and Change, Jum C. Nunnally reviewed a research program that assessed public attitudes toward the mentally ill, mental health professionals, and therapy. He concluded that

The most important finding from our studies of public attitudes is that the stigma [toward the mentally ill] is very general, both across social groups and across attitude indicators. There is a strong "negative halo" associated with the mentally ill. They are considered, unselectively, as being all things "bad." Some of the "bad" attitudes that people have toward the mentally ill are partially supported by facts—for example, the mentally ill sometimes are unpredictable and dangerous. However, the average man generalizes to the point of considering the mentally ill as dirty, unintelligent, insincere, and worthless. (p. 233)

Since the completion of Nunnally's research, there have been remarkable changes in the systems of treating people with mental disorders (Green, McCormick, Walkey, & Taylor, 1987). This movement has been away from institutional, managed care toward rehabilitation and integration of the mentally ill into the community. Paralleling this transformation has been the rise of the mental health movement, greater financial support of mental health research and increased popularity of "social deviance" approaches to the

treatment of mental disorders, as epitomized by the work of T. S. Szasz (Olmsted & Durham, 1976).

Given these changes in the mental health system over the last 30 years, it seems reasonable to think that the general public's attitudes toward the mentally ill would be significantly more favorable than Nunnally found. However, the limited systematic research on this topic during the 1960s, 1970s, and 1980s has essentially confirmed his original conclusions. This consistency seems surprising in light of revolutionary changes in how mental disorders are both conceptualized and treated in many professional circles.

The purpose of the current research is threefold: (a) to ascertain if stigma is still attached to people with mental disorders; (b) to establish that the general public¹ still assigns more favorable attitudes toward mental health professionals, and (c) to document that seeking help from a mental health professional and having a satisfactory experience with such a professional significantly impacts one's attitudes toward either the mentally ill or mental health professionals.

This study was undertaken on the assumption that the effects of interactions between mental health professionals and their clients help shape attitudes on a broader societal level. If clinical psychologists are to take their

¹Olmsted & Ordway (1963) empirically determined that responses of a college student sample to Nunnally's original eight concepts and 12 scales were highly similar to Nunnally's sample, which was selected to reflect current demographics. Therefore, the phrase "general public" will refer to both types of samples.

clients' social realities seriously, then one way of doing so is to first understand that any client is imbedded in a matrix of ongoing relationships that affect his or her attitudes toward the therapeutic relationship.

Furthermore, to the extent that mental health professionals are experts in their field, they tend to be victims of "trained incapacity" (Bissfield & Munger, 1985). That is, they may be highly knowledgeable about mental health therapy and service delivery but have an insufficient understanding of the forces of public opinion that surround their activities. While clinical psychologists need to learn all they can about each individual client, they also need to be sensitive to the larger social contexts in which their clients function.

Literature Review of Mental Health Attitudes

Nunnally's research in the 1950s involved over 500 individuals in several geographic locations. Different groups were asked to complete either a 60-item questionnaire requesting them to rate their level of agreement with statements about mental health problems or a semantic differential measure that asked for their ratings of such mental health concepts as "mental patient," "average man," "psychiatrist," and "me." The semantic differential scales were later analyzed and found to contain four dimensions: evaluation, defined by scales such as good-bad; potency, defined by scales like strong-weak; activity, defined by scales such as active-passive, and understandability, defined by such scales as understandable-mysterious.

As evidence for the lack of structure surrounding mental health attitudes, 10 factors identified by Nunnally (1961; the mentally ill look and act differently, mental disturbances can be avoided by thinking pleasant thoughts, mental illness is a manifestation of the lack of will power, and so forth) accounted for less than 25% of the total variance among his items. In addition, there was appreciable agreement with inconsistent statements, suggesting a lack of crystallization of attitudes toward mental health issues.

This ambiguity seems to suggest that the "average man" was not very well informed about the causes and treatment of many mental disorders. However, Nunnally's results indicated that this was not the case. On most information factors examining the causes and characteristics of mental disorders, the mean responses for the general public were not markedly different from the mean responses for a sample of mental health professionals (Nunnally, 1961). These findings suggest a rather positive outlook in terms of what the public knows about mental health issues, but paints a darker picture in terms of how the public feels about such issues and the mentally ill.

There has been very little systematic follow-up of Nunnally's 1961 findings. Most subsequent research has focused on special populations and/or narrower aspects of Nunnally's study. The more systematic studies have demonstrated a surprising degree of consistency with Nunnally's results and form the foundation for the hypotheses outlined at the end of this chapter.

Two U.S. studies by Olmsted and Ordway (1963) and Olmsted and Durham (1976) examined the degree of similarity between Nunnally's (1961) results, based on attitudes of the general public, and college students. The results reported by Olmsted and his colleagues are significant in two aspects: One, the general public and college students closely co-varied in their attitudes toward the mentally ill, with any differences shown in intensity of attitude rather than in direction or dimension, and two, Nunnally's findings were generally substantiated. However, the concept of "ex-mental patient" correlated more strongly with the concept "average man" in both 1962 and 1971 ($r = .95$ and $.92$, respectively) than with "mental patient" or "insane person" in both years (Olmsted & Durham, 1976).

These findings, while appearing simple, suggest a more complex underlying phenomenon. First, how does one account for the fact that the responses of Nunnally's samples, chosen to approximate the U.S. adult population in social characteristics, correlated very highly (.90 or more) with two samples of college students, typically unrepresentative of the general public? A possible answer noted by Olmsted and Durham (1976) is that when one refers to "popular conceptions of mental health," one is speaking of a "collective phenomenon" (p. 43), which cancels out individual differences in attitudes. According to these authors, this phenomenon is highly resistant to modification by "external" forces, such as educational campaigns by mental health professionals. It may be recalled that Nunnally (1961) found that

mental health attitudes were neither highly structured nor highly crystallized, implying that these attitudes should be somewhat malleable. Olmsted and Ordway's (1963) and Olmsted and Durham's (1976) results appear to contradict this assumption. Furthermore, it appears that the prevailing professional opinions regarding the mentally ill, as popularized by models that emphasize social deviance, are inconsistent with the general public's attitudes, creating further barriers to public acceptance of community-based mental health programs. This stigma of being a "mental patient" probably contributes to some people's reluctance to seek mental health services when needed. Bursztajn and Barsky (1985) noted that many medical patients who could benefit from a psychiatric referral reject these referrals because of the social stigma associated with the "psychiatric patient" label.

A hopeful feature of Olmsted and Durham's (1976) research—that the concept "ex-mental patient" was related in the public's mind more closely to "average man" than to "mental patient" or "insane person"—implies that the public believes that mental disorders and the stigmatization associated with them are not necessarily permanent.

Green, McCormick, Walkey, and Taylor (1987) surveyed 215, 232, and 328 New Zealand college students in 1978, 1981, and 1984, respectively, and compared their results with Olmsted and Ordway's (1963) and Olmsted and Durham's (1976) U.S. findings. They concluded that attitudes toward the mentally ill and mental health professionals were remarkably consistent

across all five U.S. and New Zealand samples. There were persistently unfavorable attitudes toward people with mental disorders and persistently favorable attitudes toward mental health professionals, although the concepts measuring attitudes correlated more strongly intranationally than internationally. The New Zealand students also viewed "ex-mental patient" more favorably than did Nunnally's (1961) subjects. Furthermore, Green et al. (1987) found no differences in attitudes toward the mentally ill associated to standard demographic variables as age, sex, and education. The authors concluded that "until those attitudes [toward the mentally ill] do improve, the prevailing political and professional trends toward 'deinstitutionalization' and community care are unlikely to succeed" (pp. 421-422) and that mental health professionals "can no longer rely on the comforting assumption that the modern community is more enlightened and more tolerant about mental health matters than in the past" (p. 422).

In related research, Furnham and Pendred (1983) found that mental health attitudes were consistently more favorable toward the physically handicapped than toward the mentally handicapped. While their research focused on physical and mental handicaps such as blindness and Down's syndrome, Nunnally (1961) found that while many in his sample rated "someone who was born blind" as weak, passive, slow, delicate, worthless, and sick, they rated the mentally disordered even more negatively. Survey respondents in Socall and Holtgraves's 1992 study rejected a hypothetical

mentally ill person significantly more than an identically behaving physically ill person [emphasis added]. This lends support to the theory that people labeled as mentally ill experience negative societal reactions.

In an area of research that used a different method of measuring attitudes, Bissfield and Munger (1985) reported two clusters of attitudes toward people with mental disorders. Pessimistic egalitarians were distinguished by believing what these authors called the "democracy of epidemiology" (p. 516) and the irrelevance of gender, ethnicity, and economic level to the incidence of mental illness. Their pessimism derived from the evidence that most people fear and dislike people with mental disorders. Conversely, optimistic social stress theorists linked mental illness to social conditions and were more apt to believe that most people are kindly disposed toward the mentally ill. They also reported that younger respondents tended to be "pessimistic egalitarians," while older persons tended to favor the "optimistic social stress" theory. Bissfield and Munger posited that "younger generations may be learning a body of preferred statements that de-emphasize the social factors in the epidemiology of mental illness in favor of an egalitarianism that may be superficially appealing but is not based on fact" (p. 516). These younger participants did not seem to believe that demographic variables such as gender, economic condition, and ethnicity play a role in the epidemiology of mental illness.

It should be noted here that the results of all the studies described thus far were not strongly associated with standard demographic variables.

However, other studies have taken a closer look at mental health attitudes in tandem with demographic variables to see if there are any discernable differences across groups in attitudes toward the mentally ill and mental health professionals.

One such study surveyed 321 white and 192 African-American school teachers (Hall & Tucker, 1985). Their results revealed that African-Americans held more stereotypic views of mental illness, while whites' views were closer to those of mental health professionals. Conception of mental illness was not significantly related to whether any participants had received psychological help prior to the study. However, conception of mental illness associated negatively with help-seeking attitudes: As attitude scores toward seeking professional help became more positive, conception became less stereotypic and more professionally oriented.

Comparisons of the mental health attitudes of rural and urban populations have also been studied. In a two-county rural area of North Carolina, Edgerton and Bentz (1969) found that attitudes toward the mentally ill and mental hospitals have "clearly changed over the past 20 years" (p. 477). Also, they found that rural dwellers "overwhelmingly accept the role of the psychiatrist as unique, both for themselves, family members, and friends" (p. 477). While both the urban and rural samples believed that mental

illness can be treated successfully, the rural sample believed that mental disorders can be prevented, while the urban sample was more pessimistic about this preventability. The authors concluded that the "traditional ways of thinking about mental illness are beginning to diminish as people become better informed" (p. 474). This view contrasts with Nunnally's (1961) findings that while people are relatively well informed about mental health issues, their corresponding attitudes do not reflect their knowledge.

A 1985 study on the perceptions of people with psychological problems and the effects of seeking counseling attempted to further define the parameters by which the general public views the mentally ill (Dovidio, Fishbane, & Sibicky, 1985). People without psychological problems were rated most favorably, followed by those with psychological problems who sought therapy, and last by people with psychological problems (no therapy). Interestingly, those without problems garnered the highest ratings for security and sociability, while people with problems who sought therapy were rated the highest of the three groups for competence and character. Although this research confirmed the results of similar studies, it extended the scope to "normal" people with psychological problems. It appears these people may be described in some favorable ways.

Last, Nunnally (1961) examined the attitudes people have toward mental health professionals and their treatment methods. He concluded that people generally hold favorable attitudes toward mental health professionals

such as doctors, nurses, psychiatrists, and psychologists, with professionals who treat physical ailments rated somewhat higher than those who treat psychological disorders. Furthermore, the general public made few connotative distinctions among such mental health professionals as psychologists, psychoanalysts, clinical psychologists, and research psychologists.

What the general public did make distinctions among, however, were the treatment techniques used by mental health professionals and those used by physicians. The public did not trust mental-treatment methods and institutions as much as physical-treatment methods and institutions (Nunnally, 1961). So while the public held mental health professionals in relatively high regard, their treatment methods were a source of general mistrust and fearfulness.

In a related area of research, Sharpley (1985) surveyed 502 Australians on their knowledge of and attitudes toward four mental health professionals: psychiatrists, psychologists, social workers, and counselors. He found these four professions were perceived as providing fairly distinctive services to the public and fell into two subgroups: Psychologists and psychiatrists were viewed as private, fee-demanding professionals who study human behavior and thought, while social workers and counselors were seen as public-utility, non-fee-demanding professionals who are more practical and help the average person solve emotional problems. While the psychiatrists

and psychologists were viewed as having higher status than either social workers or counselors, they were also viewed as "odder" and more difficult to talk to in social situations. According to Sharpley, these results pointed to two possible conclusions: The public holds a "mentally ill" vs. "normal but troubled" dichotomy when it comes to attitudes toward people with mental disorders, and the "academic" image of psychologists is most prominent in the public's mind, with only people who are very different from the norm seeking out the services of psychologists and psychiatrists.

In a study addressing elderly persons' attitudes toward mental health professionals, Woodruff, Donnan, and Halpin (1988) concluded that persons over the age of 60 generally have less favorable attitudes than younger people. However, these attitudes are responsive to educational programs on mental health issues and treatments that focus on the elderly's specific concerns.

Hypotheses

This study seeks to build upon the work begun by Nunnally and continued by Olmsted and Ordway (1963) and Green and associates by examining the current status of mental health attitudes. In addition, it seeks to answer the following question: Does having a satisfactory experience with a mental health professional favorably impact upon attitudes toward the

mentally ill and mental health professionals? The following five hypotheses are thus posed:

Hypothesis 1: The public will attach stigma to the mentally ill. For purposes of this hypothesis, "stigma" means a less favorable attitude than accorded to both themselves and mental health professionals. This hypothesis has implications for the beliefs and attitudes of the people referred to in Hypotheses 2 through 5.

Hypothesis 2: The public will hold moderately favorable attitudes toward mental health professionals. For purposes of this hypothesis, "moderately favorable" means a more favorable attitude than accorded to the mentally ill and a not-as-favorable attitude than accorded to themselves. Again, this hypothesis presumably applies to the people referred to in Hypotheses 3 through 5.

Hypothesis 3: Attitudes toward the mentally ill and mental health professionals have become more favorable across time. "Attitudes toward the mentally ill" and "attitudes toward mental health professionals" are the same as those discussed in Hypothesis 2. "Across time" refers to the assumption that the results of this study on attitudes toward the mentally ill and mental health professionals will differ from Olmsted and Ordway's (1963), Olmsted and Durham's (1976) and Green et al.'s results.

Hypothesis 4: Having a personal experience with a mental health professional will favorably impact one's attitudes toward the mentally ill and mental health professionals.

Hypothesis 5: Having a satisfactory experience with a mental health professional will favorably impact one's attitudes toward the mentally ill and mental health professionals.

For purposes of Hypotheses 4 and 5, "experience" means having experienced a mental health situation involving the use of professional services at any one of two levels: (a) the person being surveyed was a mental health client, or (b) the person being surveyed has had a family member (either extended family or "living together" family) or close friend or romantic partner who was a mental health client. The term "experience" is defined this broadly in order to improve the chances that the sample will include enough cases with at least some kind of experience so analysis can be meaningful. With respect to the two experience levels: At the first level, respondents will be asked about how satisfactory their experience was, and at the second level, they will be asked about their impression of the satisfactoriness of the experiences of others.

Hypotheses 4 and 5 cannot be derived by strict logic from Hypotheses 1 and 2. However, they are not logical contradictions of either Hypothesis 1 or 2. The basis for the last two hypotheses is twofold. First, as stated in the literature review, mental health attitudes are assumed in this study to be a

collective phenomenon and a fairly stable system of cultural beliefs and, therefore, very resistant to change. However, it is possible that one favorable experience could ameliorate a lifetime of previous experiences. Furthermore, many successful users of mental health services may view themselves as "essentially normal but troubled," rather than "mentally ill" and, therefore, may be similarly disposed toward seeing others in the same light.

CHAPTER TWO

METHODOLOGY

Participants

Four hundred seventy-two students from a local community college participated in the study. The number of participants used was based upon attaining comparability with the research conducted by Olmsted and Ordway (1963), Olmsted and Durham (1976) and Green et al., who studied from 215 to 328 college students.

Everyone enrolled in the laboratory-based sections of introductory psychology was asked to participate in this study as part of a weekly activity on research methods. The general nature of the study was described, and informed consent obtained. All students agreed to participate and were debriefed after completing the study.

Measures

All responded to a semantic differential measure, innocuously presented as a "word-association study" (Appendix A). In addition, students were asked to provide anonymous information about their age, sex, race, and whether they, a family member, or close friend had ever consulted a mental

health professional (Appendix B). The semantic differential of eight concepts was identical to the instrument used by Olmsted and Ordway (1963), Olmsted and Durham (1976) and Green et al., except that the concepts "psychologist" and "troubled person" were added. All 10 concepts were rated by participants on 12 seven-point scales such as "valuable-worthless," "sincere-insincere," and "predictable-unpredictable." Standard instructions were given, and the direction of the scales was alternated to inhibit the use of response sets.

Table 1 provides demographic information--age, sex, race, and highest level of education completed by either parent--for the 472 respondents. A chi-square analysis was conducted to determine if there was any systematic relationship between these demographic variables and mental health concepts measured. The results were not statistically significant ($p < .05$, two-tailed) for any demographic variable.

Analysis

Ratings of four concepts ("mental patient," "insane person," "ex-mental patient," and "troubled person") were regarded measures of the dependent variable, favorableness of attitudes toward the mentally ill. Ratings of the concepts "doctor," "psychiatrist," and "psychologist" were regarded as the dependent variable, favorableness of attitudes toward mental health

Table 1: Sample characteristics (N = 472).

Characteristic	Frequency	Percent
<u>Age Range</u>		
18-24	393	83.3
25-29	16	3.4
30-39	30	6.4
40-49	14	3.0
50-59	4	0.8
60-69	1	0.2
70-79	0	0.0
80-89	1	0.2
No response	13	2.8
Total	472	100.0
<u>Sex</u>		
Female	297	62.9
Male	163	34.5
No response	12	2.5
Total	472	100.0
<u>Race</u>		
Caucasian	405	85.8
Hispanic	20	4.2
Black	16	3.4
Asian	15	3.2
Native American	4	0.8
No response	12	2.5
Total	472	100.0
<u>Highest Level of Education Completed by Either Parent</u>		
High school	177	37.5
Four-year college	115	24.4
Trade school	77	16.3
Graduate school	73	15.5
Grade school	5	1.1
Middle school	4	0.8
Don't know	14	3.0
No response	7	1.5
Total	472	100.0

professionals. The concepts "me," "most people," and "average person"² were included as anchors to provide a more complete frame of reference.

Grand means, e.g., "doctor," and scale-concept means, e.g., "doctor" combined with "valuable-worthless," are displayed in Table 2. The grand mean is the average of the ratings of each concept on the series of 12 semantic differential scales. Since the hypotheses stated expectations as to the favorability of attitudes, it was necessary to designate a "positive" and "negative" end for each scale. Most of the scales have obvious positive and negative poles, such as "clean-dirty," while others, such as "simple-complicated," are less clear. In the previous studies (Olmsted & Ordway, 1963; Olmsted & Durham, 1976, and Green et al.), the positive and negative ends of these ambiguous scales were determined empirically by observing which pole of the "non-obvious" scales correlated positively with the positive pole of the "obvious" scales (Table 3). This study used the same method.

Hypotheses 1 and 2 were examined using a technique developed by Blizzard (1969), which uses the mean rating for "average person" as an anchor value on each of the 12 scales. This value was subtracted from the corresponding scale mean ratings for each of the concepts under investigation. A positive sign associated with this value indicates that the critical concept is seen as more favorable on the various scale concepts than

²In this study, the concept "average man" was changed to "average person" to reduce gender bias.

Table 2: Semantic differential means/standard deviations: Ten concepts by 12 scales (1996).

Scale	Me	Doctor	Psychologist	Psychiatrist	Average Person	Ex-Mental Patient	Most People	Mental Patient	Troubled Person	Insane Person
Valuable-Invaluable	6.24/ 1.05	6.57/ 0.79	5.73/ 1.35	5.54/ 1.52	4.97/ 1.90	5.43/ 1.31	5.56/ 1.44	4.81/ 1.68	4.94/ 1.60	3.77/ 1.90
Sincere-Insincere	6.09/ 1.30	5.23/ 1.52	5.36/ 1.47	5.16/ 1.64	4.55/ 1.66	4.94/ 1.20	4.34/ 1.58	4.24/ 1.50	4.03/ 1.64	3.58/ 1.81
Warm-Cold	5.93/ 1.30	4.87/ 1.46	5.12/ 1.43	5.05/ 1.61	4.49/ 1.42	4.62/ 1.17	4.33/ 1.43	3.87/ 1.39	3.45/ 1.41	3.24/ 1.52
Fast-Slow	4.86/ 1.42	4.06/ 1.78	3.68/ 1.45	3.42/ 1.54	4.23/ 1.02	3.98/ 0.98	4.26/ 1.23	3.39/ 1.36	3.98/ 1.31	3.66/ 1.69
Rugged-Delicate	3.03/ 1.65	2.83/ 1.41	2.98/ 1.30	2.82/ 1.36	3.64/ 1.18	3.32/ 1.20	3.99/ 1.19	3.73/ 1.61	3.92/ 1.71	4.46/ 1.83
Relaxed-Tense	4.13/ 1.83	4.96/ 1.74	5.11/ 1.61	5.39/ 1.75	3.93/ 1.40	3.44/ 1.31	3.15/ 1.42	2.51/ 1.36	1.99/ 1.08	2.06/ 1.36
Clean-Dirty	6.51/ 0.99	6.68/ 0.82	5.62/ 1.37	5.81/ 1.26	4.79/ 1.59	4.95/ 1.22	4.67/ 1.28	4.17/ 1.35	4.48/ 1.30	3.56/ 1.38
Safe-Dangerous	5.74/ 1.54	5.92/ 1.34	5.27/ 1.51	5.21/ 1.61	4.43/ 1.42	4.16/ 1.20	4.19/ 1.38	3.02/ 1.29	3.01/ 1.23	2.41/ 1.37

Table 2: Continued.

Scale	Me	Doctor	Psycholo- gist	Psychia- trist	Average Person	Ex-Mental Patient	Most People	Mental Patient	Troubled Person	Insane Person
Wise-Foolish	5.20/ 1.27	6.09/ 1.20	5.66/ 1.37	5.52/ 1.50	4.28/ 1.27	4.16/ 1.00	3.88/ 1.34	3.38/ 1.24	3.17/ 1.18	3.00/ 1.39
Strong/Weak	5.34/ 1.30	5.20/ 1.27	4.84/ 1.33	4.86/ 1.48	4.28/ 1.15	4.30/ 1.15	4.07/ 1.24	3.60/ 1.41	3.58/ 1.42	3.69/ 1.68
Predictable- Unpredictable	4.24/ 1.77	4.79/ 1.58	3.97/ 1.62	3.87/ 1.78	4.20/ 1.48	3.69/ 1.35	4.08/ 1.79	2.45/ 1.45	2.69/ 1.54	1.92/ 1.34
Complicated- Simple	5.59/ 1.13	5.49/ 1.06	5.54/ 1.12	5.68/ 1.13	5.10/ 1.01	5.18/ 1.03	5.33/ 1.15	5.87/ 1.10	5.60/ 1.32	6.23/ 1.09
GRAND MEANS	5.24/ 1.02	5.22/ 1.07	4.91/ 0.89	4.85/ 0.96	4.41/ 0.41	4.35/ 0.69	4.32/ 0.64	3.75/ 0.96	3.74/ 0.99	3.47/ 1.15

Table 3: Semantic differential concepts and scales.

Concept	Bipolar Scale ^a
Doctor	Valuable-worthless ^b
Psychiatrist	Sincere-insincere ^b
Psychologist	Warm-cold ^c
Most people	Fast-slow ^c
Insane people	Rugged delicate ^d
Me	Relaxed-tense ^b
Average person	Clean-dirty ^b
Mental patient	Safe-dangerous ^b
Ex-mental patient	Wise-foolish ^b
Troubled person	Strong-weak ^b
	Predictable-unpredictable ^c
	Complicated-simple ^d

^aThe positive pole is given first.

^bThe positive pole for these scales has been consistently verified by scale intercorrelations of above 0.90 for the 1962, 1971, and 1978 samples.

^cThe positive pole of these scales is less "obvious" but has also been shown to be highly correlated (above 0.85) in the 1978, 1981, and 1984 samples.

^dThese scales show some level of intercorrelation; therefore assignment of a positive pole is a matter of convenience (Green et al., 1987).

that of the concept "average person;" a negative sign indicates the critical concept was regarded as less favorable. The mean differences for the seven mental health concepts measured—"doctor," "psychiatrist," "psychologist," "patient," "insane person," "ex-mental patient" and "troubled person" were computed with this procedure and displayed in Table 4. The grand mean of differences, which is the average of the differences between "average man" and each concept across the 12 semantic differential scales, is also shown in Table 4.

With respect to the hypothesis that the public holds stigmatic attitudes toward the mentally ill, the concepts "insane person" and "mental patient" were expected to yield negative values on all or almost all scales. The concepts "ex-mental patient" and "troubled person" should yield generally negative values but to lesser degrees than the preceding comparisons. Finally, the interpretation that the public attaches stigma to the above concepts is strengthened to the extent that the comparable means are more positively valued for "doctor," "psychiatrist," and "psychologist" than for "average person." These same data would lend support to Hypothesis 2.

To assess the stability of mental health attitudes, the values calculated for Hypotheses 1 and 2 were compared to the 1962, 1971, 1978, 1981, and 1984 samples by using Pearsonian correlations. Substantial positive correlation coefficients would support the idea, forwarded by Olmsted and

Table 4: Mean differences of seven mental-health-related concepts compared with "average person" (1996 sample).

Descriptive Trait	Doctor	Psychologist	Psychiatrist	Ex-Mental Patient	Mental Patient	Troubled Person	Insane Person
Valuable-worthless	1.60	0.76	0.48	0.46	-0.16	-0.03	-1.20
Sincere-insincere	0.68	0.81	0.61	0.39	-0.31	-0.52	-0.97
Warm-cold	0.38	1.63	0.56	0.13	-0.62	-1.04	-1.25
Fast-slow	-0.17	-0.55	-0.81	-0.25	-0.84	-0.25	-0.57
Rugged-delicate	-0.81	-0.68	-0.82	-0.32	0.09	0.28	0.82
Relaxed-tense	1.03	1.18	1.46	-0.49	-1.42	-1.94	-1.87
Clean-dirty	1.89	0.83	1.02	0.16	-0.62	-0.31	-1.23
Safe-dangerous	1.69	0.84	0.78	-0.27	-1.41	-1.42	-2.02
Wise-foolish	1.81	1.38	1.24	-0.12	-0.90	-1.11	-1.28
Strong-weak	0.92	0.56	0.58	0.02	-0.68	-0.70	-0.59
Predictable-unpredictable	0.59	-0.23	-0.33	-0.51	-1.75	-1.51	-2.28
Complicated-simple	0.39	0.44	0.58	0.08	0.77	0.50	1.13
Grand Mean of Differences	0.83	0.58	0.45	-0.06	-0.66	-0.68	-0.94

Durham (1976) and Green et al. that mental health attitudes are stable across time.

Hypotheses 4 and 5 were tested using the current data and t-tests.

These data were partitioned as follows: (a) respondents with no "experience" with a mental health professional; (b) those with "experience" as clients, and (c) respondents with "experience" involving family members, close friends or romantic partners. The latter two categories were also partitioned with expressed feelings of "satisfaction" with the mental health professional. All of these categories are intended to indicate different values of the independent variable, while the dependent variable in the analysis is attitudes toward the mentally ill and mental health professionals. These values, then, represent the distinctiveness of each concept as compared with views of "everyday" or "typical" people, and the magnitude of the resulting values can be viewed as a rough quantification of that distinctiveness. The goal, then, is to determine if and how different patterns of experience affect expressions of attitude.

CHAPTER THREE

RESULTS

The hypothesis that the public attaches stigma to people with mental disorders was confirmed. The concepts "insane person," "mental patient," and "troubled person" differed appreciably from the concept "average person" in the Table 2 data ($t = -17.77, -14.93, \text{ and } -14.69$, respectively; $p < .005$). On scales that ranged from -3 through 0 to +3, an "insane person" was characterized as being more unpredictable ($M_{\text{diff}} = -2.28$), dangerous ($M_{\text{diff}} = -2.02$), dirty ($M_{\text{diff}} = -1.23$) and worthless ($M_{\text{diff}} = -1.20$) than the "average person." Over the set of 12 scales, the grand mean difference (-.94) of ratings for "insane person" versus that for "average person" was distinctly less favorable.

Also given in Table 2, the parallel grand mean differences of ratings for "troubled person" and "mental patient" were -.68 and -.66, respectively. A "troubled person" was viewed as being more tense ($M_{\text{diff}} = -1.94$) and unpredictable ($M_{\text{diff}} = -1.51$). A "mental patient" was also rated as being relatively unpredictable ($M_{\text{diff}} = -1.75$) and tense ($M_{\text{diff}} = -1.42$).

Across the 12 descriptor scales, the grand mean of ratings for "ex-mental patient," when compared with "average person," did not reach statistical significance. "Ex-mental patient" had mean differences from "average person" that ranged from more unpredictable ($M_{diff} = -.51$) to more valuable ($M_{diff} = .46$). This may indicate little consistency in how the present sample viewed an "ex-mental patient," as this concept was rated as roughly similar to the "average person."

That the public attaches moderately favorable attitudes toward mental health professionals was also confirmed. The concepts "doctor," "psychologist," and "psychiatrist" differed substantially and favorably from the concept "average person" ($t = 16.43, 12.20, \text{ and } 9.95$, respectively; $p < .005$). The grand mean of ratings on the 12 descriptors, as compared to "average person," were .83, .58 and .45 for "doctors," "psychologists," and "psychiatrists," respectively.

Table 2 data demonstrate that relative to "average person," "doctors" were rated as notably clean ($M_{diff} = 1.89$) and wise ($M_{diff} = 1.81$). The parallel differences that best described "psychologists" were wise ($M_{diff} = 1.38$) and relaxed ($M_{diff} = 1.18$). "Psychiatrists" were similarly characterized as being relaxed ($M_{diff} = 1.46$) and wise ($M_{diff} = 1.24$).

The hypothesis that attitudes toward the mentally ill and mental health professionals have become more favorable during the last 35 years was not

confirmed. This was particularly true for the two most stigmatized concepts: "mental patient" and "insane person."

Mental Patient

Table 5 displays the mean differences between the concepts "average person" and "mental patient" for the 12 semantic differential scales across six separate studies. Not only is the relative unfavorableness of attitudes toward mental patients nearly the same over these various studies, as shown by the grand means, but the related correlations across the mean scores on these semantic differential scales indicate that the structure of these attitudes did not differ discernibly. When comparing the 1981 New Zealand data to the 1962 U.S. sample, correlation coefficients ranged from .65 ($p = .02$) to .98 ($p < .01$). The current data (1996) yielded correlation coefficients ranging from .70 ($p < .01$) to .82 when compared to the five earlier studies.

Post-hoc analyses compared the composite mean differences from the five earlier studies with the 1996 mean differences using variance estimates based on the current sample because standard deviations were not accessible for these past works. These data showed that the 1996 respondents viewed "mental patients" as more rugged versus delicate, more valuable than worthless, and more predictable than unpredictable ($t = 13.63$, 8.02 , and 6.45 , respectively; $p < .005$). A stringent Bonferroni correction ($t_{crit} = 5.152$) was used with these comparisons to control for familywise error.

Table 5: Mean differences in ratings of "mental patient" versus "average person."

Descriptive Trait	1996 (N=472)	1984 (N=328)	1981 (N=232)	1978 (N=215)	1971 (N=319)	1962 (N=215)
Unpredictable	-1.72	-2.44	-2.08	-2.45	-1.94	-1.80
Tense	-1.42	-1.90	-1.38	-1.47	-1.42	-1.50
Dangerous	-1.41	-1.67	-1.33	-1.33	-1.59	-1.75
Foolish	-0.90	-0.56	-0.56	-0.73	-0.87	-0.94
Slow	-0.84	-0.81	-0.75	-0.68	-1.02	-0.78
Weak	-0.68	-0.66	-0.47	-0.89	-1.57	-1.24
Cold	-0.62	-0.49	-0.24	-0.41	-0.41	-0.96
Dirty	-0.62	-0.47	-0.34	-0.45	-0.75	-0.99
Insincere	-0.31	0.09	0.22	-0.12	-0.25	-0.78
Worthless	-0.16	-0.96	-0.73	-0.68	-0.70	-0.77
Rugged	0.09	-0.83	-0.80	-0.87	-1.11	-0.94
Complicated	0.77	1.46	1.16	1.16	0.50	0.53
Grand Mean	-0.66	-0.77	-0.61	-0.77	-0.93	-0.99
Correlation with 1996		.79*	.77*	.82*	.70*	.79*
Correlation with 1984			.98*	.96*	.71*	.68*
Correlation with 1981				.97*	.71*	.65*
Correlation with 1978					.82*	.77*
Correlation with 1971						.87*

* $p < .05$, two-tailed.

Insane Person

As with "mental patient," both the relative unfavorableness of the "insane person" construct and its structure appear to have remained relatively constant in the United States since 1963, as shown in Table 6. Here, correlation coefficients over the 12 descriptor scales ranged from .63 ($p = .03$) when comparing the 1984 New Zealand data to the 1962 U.S. data to .97 when comparing the 1984 and 1978 New Zealand samples. When compared to each of the five previous studies, the new 1996 U.S. data had correlation coefficients ranging from .78 to .94 ($p < .01$).

Compared to the composite means based on the five prior studies, the 1996 respondents viewed the concept "insane person" differently on the semantic differential scales toward rugged versus delicate ($t = 16.98$) and dirty versus clean ($t = 5.35$).

Ex-mental Patient

The parallel means for "ex-mental patient," given in Table 7, yielded a more complex picture. For the 1978, 1981, and 1984 New Zealand studies, the 12 descriptors correlated substantially with the 1971 U.S. study ($r = .73$, $r = .59$ and $r = .66$, respectively; $p < .05$). Among the three New Zealand studies, very high correlations (.83, .89, and .97) were also found. Surprisingly, the 1996 U.S. data had no statistically significant associations with any of the prior studies. When tested for statistical significance using

Table 6: Mean differences in ratings of "insane person" versus "average person."

Descriptive Trait	1996 (N=472)	1984 (N=328)	1981 (N=232)	1978 (N=215)	1971 (N=319)	1962 (N=215)
Unpredictable	-2.28	-2.78	-2.45	-2.71	-2.35	-2.23
Dangerous	-2.02	-2.47	-2.26	-2.25	-2.44	-2.09
Tense	-1.87	-2.10	-1.59	-1.78	-1.30	-1.60
Foolish	-1.28	-0.93	-0.89	-1.13	-1.08	-1.32
Cold	-1.25	-1.26	-0.85	-1.02	-1.02	-1.10
Dirty	-1.23	-0.86	-0.49	-0.76	-1.05	-1.25
Worthless	-1.20	-1.38	-0.98	-0.99	-0.95	-1.11
Insincere	-0.97	-0.89	-0.35	-1.06	-0.79	-0.65
Weak	-0.59	-0.33	-0.21	-0.51	-0.95	-1.40
Slow	-0.57	-0.13	-0.21	-0.20	-0.47	-0.89
Rugged	0.82	-0.34	-0.56	-0.35	-0.81	-1.05
Complicated	1.13	1.81	1.38	1.49	0.60	0.55
Grand Mean	-0.94	-0.97	-0.79	-0.94	-1.05	-1.18
Correlation with 1996		.94*	.93*	.94*	.88*	.78*
Correlation with 1984			.96*	.97*	.79*	.63*
Correlation with 1981				.95*	.85*	.72*
Correlation with 1978					.84*	.69*
Correlation with 1971						.93*

* $p < .05$, two-tailed.

Table 7: Mean differences in ratings of "ex-mental patient" versus "average person."

Descriptive Trait	1996 (N=472)	1984 (N=328)	1981 (N=232)	1978 (N=215)	1971 (N=319)	1962 (N=215)
Unpredictable	-0.51	-0.74	-0.57	-0.78	-0.44	0.00
Tense	-0.49	-0.65	-0.60	-0.55	0.27	0.26
Delicate	-0.32	-0.88	-0.77	-0.62	-0.71	-0.52
Dangerous	-0.27	-0.34	-0.34	-0.40	-0.32	-0.20
Slow	-0.25	-0.20	-0.09	-0.22	-0.39	-0.47
Foolish	-0.12	0.45	0.46	0.09	0.05	0.09
Strong	0.02	-0.03	0.00	-0.18	-0.11	-0.21
Complicated	0.08	0.86	0.83	0.69	0.24	0.11
Warm	0.13	-0.13	0.02	-0.10	0.04	-0.22
Clean	0.16	-0.13	0.17	0.05	-0.02	-0.13
Sincere	0.39	-0.28	0.39	0.29	0.30	0.14
Valuable	0.46	-0.13	0.07	0.09	-0.08	-0.10
Grand Mean	-0.06	-0.12	-0.04	-0.14	-0.10	-0.10
Correlation with 1996		.29	.24	.39	.44	.05
Correlation with 1984			.97*	.89*	.66*	.08
Correlation with 1981				.83*	.59*	.02
Correlation with 1978					.73*	.04
Correlation with 1971						.57

* $p < .05$, two-tailed.

Fisher's r to z transformation, the composite coefficient of the three U.S. studies differed from that of the three New Zealand studies ($t = 2.59$, $p < .05$). Thus, there appear to be some appreciable differences in how Americans and New Zealanders view "ex-mental patients."

Post-hoc comparisons of the 1996 data with the combined five previous studies showed that the new U.S. sample viewed "ex-mental patients" more favorably on the semantic differential scales of valuable versus worthless and rugged versus delicate ($t = 8.22$ and 7.25 , respectively; $p < .005$) and less favorably on the scales of simple versus complicated and foolish versus wise ($t = 9.92$ and 7.83 , respectively; $p < .05$).

Doctor

The general level of favorableness of "doctor" ratings appears fairly constant over the 35-year time span. The correlation coefficient between the 1962 and 1971 U.S. data was .95 ($p < .01$). In addition, the correlation coefficients among the three New Zealand studies ranged from .91 and .98. While the correlation coefficients between the 1996 data and the three New Zealand studies ranged from .83 to .87 (Table 8), the correlation coefficients between the two earliest U.S. studies (1962 and 1971) and the current study were only .57 ($p = .05$) and .47 ($p = .12$).

As compared to the five-study composite, the 1996 respondents rated "doctors" as more valuable ($t = 14.56$), safe ($t = 12.16$), clean ($t = 10.34$), slow ($t = 8.79$), and simple ($t = 7.17$).

Table 8: Mean differences in ratings of "doctor" versus "average person."

Descriptive Trait	1996 (N=472)	1984 (N=328)	1981 (N=232)	1978 (N=215)	1971 (N=319)	1962 (N=215)
Clean	1.89	1.76	1.82	1.73	1.12	1.12
Wise	1.81	1.53	1.69	1.57	1.39	1.45
Safe	1.69	1.21	1.00	1.06	0.67	0.75
Valuable	1.60	1.04	1.40	1.41	0.80	0.85
Relaxed	1.03	0.98	1.02	1.03	1.28	1.39
Strong	0.92	0.82	0.96	1.09	1.21	1.11
Sincere	0.68	0.96	1.09	1.10	0.89	0.95
Predictable	0.59	0.50	0.46	0.32	0.75	0.86
Complicated	0.39	0.86	0.79	0.90	0.62	0.50
Warm	0.38	0.18	0.30	0.28	0.40	0.45
Slow	-0.17	0.34	0.47	0.62	0.72	0.64
Delicate	-0.81	-1.16	-1.04	-0.89	0.03	0.39
Grand Mean	0.81	0.75	0.83	0.85	0.82	0.87
Correlation with 1996		.85	.87*	.83*	.47	.57
Correlation with 1984			.95*	.91*	.39	.50
Correlation with 1981				.98*	.51	.60*
Correlation with 1978					.56	.60*
Correlation with 1971						.95*

*p < .05, two-tailed.

Psychiatrist

Like "ex-mental patient," the 1996 data suggest a cultural difference between attitudes toward "psychiatrist" in New Zealand and the United States (Table 9). The correlation coefficient for relative favorableness toward "psychiatrist" in the two earlier studies was .89, and the parallel correlations among the three New Zealand studies ranged from .93 to .96 (all p s < .01). When the average coefficient among the three U.S. studies ($r = .79$) was compared that of the three New Zealand studies ($r = .95$), the difference was statistically significant ($t = 2.28$; $p < .05$).

Like the four concepts discussed above, post-hoc analyses showed that the 1996 respondents viewed the concept "psychiatrist" as more fast, unpredictable, safe, simple, and warm as compared to composite differences from the earlier five studies ($t = 11.07, 9.28, 9.04, 7.50, \text{ and } 7.45$, respectively; $p < .005$).

Users and Nonusers of Mental Health Services

The hypothesis that personal experiences with a mental health professional will favorably impact on one's attitudes toward the mentally ill and mental health professionals was largely unconfirmed. This hypothesis used only the 1996 data, given in Table 4, and the sample was divided into 160 respondents who claimed a direct experience with a mental health professional versus all others ($n = 310$). The concept means of "doctor," "psychiatrist," "psychologist," "patient," "insane person," "troubled person,"

Table 9: Mean differences in ratings of "psychiatrist" versus "average person."

Descriptive Trait	1996 (N=472)	1984 (N=328)	1981 (N=232)	1978 (N=215)	1971 (N=319)	1962 (N=215)
Relaxed	1.46	1.28	0.89	0.94	1.49	1.44
Wise	1.24	1.38	1.33	1.03	0.86	1.11
Clean	1.02	0.99	0.97	0.82	0.53	0.67
Safe	0.78	0.26	0.00	-0.02	0.00	0.32
Sincere	0.61	0.78	0.69	0.63	0.52	0.78
Complicated	0.58	1.37	1.00	1.19	0.72	0.49
Strong	0.58	0.63	0.63	0.62	0.70	0.75
Warm	0.56	0.19	0.10	-0.05	-0.08	0.21
Valuable	0.48	0.39	0.60	0.46	0.03	0.38
Unpredictable	-0.33	-0.77	-0.70	-0.65	-0.25	0.31
Slow	-0.81	0.02	0.04	-0.07	0.10	-0.30
Delicate	-0.82	-1.13	-0.90	-0.73	-0.46	-0.20
Grand Mean	0.44	0.80	0.39	0.35	0.35	0.50
Correlation with 1996		.48	.39	.35	.70*	.74*
Correlation with 1984			.93*	.96*	.79*	.59*
Correlation with 1981				.95*	.69*	.57
Correlation with 1978					.76*	.58*
Correlation with 1971						.89*

*p < .05, two-tailed.

and "ex-mental patient" were again compared for these two groups using a t -test with the stringent Bonferroni correction ($p_{crit} = .007$) to control for familywise error. Although users of mental health services viewed "insane person" and "mental patient" more favorably than nonusers, neither comparison fully attained statistical significance by this rigorous criterion ($p = .009$).

Also tested was the proposition that those respondents who have had family or friends seek mental health services would have more favorable attitudes toward both the mentally ill and mental health professionals. Using the same t -test method described above, the 258 respondents indicating that a family member and/or friend had sought professional help were compared to the 205 indicating no knowledge of such help. Among the seven concepts, only "insane person" yielded statistically significant ($p < .0001$) results. The data indicated that those respondents who said that a family member or friend had received mental health services viewed "insane person" more favorably than respondents without such knowledge.

Also tested was the hypothesis that those indicating a satisfactory experience with a mental health professional would hold a significantly more favorable view toward the mentally ill and mental health professionals than those who said they had an unsatisfactory experience. As with the previous hypothesis, the following concept means were tested with respect to statistically significant differences on the 12 semantic differential scales:

"doctor," "psychiatrist," "psychologist," "mental patient," "insane person," "troubled person," and "ex-mental patient." For the four categories of disordered persons, this hypothesis was not confirmed.

With respect to "doctor," "psychiatrist" and "psychologist," this hypothesis was supported only for the concept "psychologist." People who received some type of professional mental health service and were satisfied with that help rated "psychologist" more favorably than those respondents who reported dissatisfaction with professional help ($p = .006$).

Table 10 displays the reported use frequencies for the various mental health professionals listed in the "Experience with Mental Health Professionals" survey, along with how each profession was rated for satisfaction and dissatisfaction. Aside from a very small number of "unidentified" ($n = 10$), doctor ($n = 65$) received the strongest proportional ratings of satisfaction (81.5% satisfied vs. 18.5% dissatisfied), while social worker received the weakest. Of the 68 study participants who reported treatment from psychologists, 47 or 69% were satisfied with the help they received, while 17 or 25% were dissatisfied. Psychiatrists received weaker, but not significantly different, proportional ratings of satisfaction than psychologists (50% satisfied versus 38% dissatisfied).

The same analysis for the family and friends data, which was to compare satisfied users of mental health services vs. dissatisfied users, was not feasible due to the paucity of data that met the criteria for analysis. The

39 respondents who reported that friends and family members had unsatisfactory contacts with mental health professionals did not provide enough statistical power to be meaningfully compared to those respondents who reported satisfactory experiences ($n = 106$). Keppel (1991) indicated that such a comparison violates statistical assumptions of normality and homogeneity of variance (p. 283), making interpretation problematic.

Table 10: Satisfaction with mental health professionals (1996) ($n = 160$).

Cited Mental Health Professional	Satisfied (S)	Dissatisfied (D)	Uncertain	Ratio S/D
Doctor ($n = 97$)	81.5%	18.5%	0.0%	4.41
Clergy ($n = 26$)	73.1%	23.1%	3.8%	3.16
Psychologist ($n = 68$)	69.0%	25.0%	5.9%	2.76
Counselor ($n = 97$)	68.0%	29.9%	2.1%	2.27
Psychiatrist ($n = 50$)	50.0%	38.0%	12.0%	1.32
Social worker ($n = 24$)	54.2%	45.8%	0.0%	1.18
Unidentified other ($n = 12$)	83.3%	8.3%	8.3%	10.00

CHAPTER FOUR

DISCUSSION

This study had two purposes: (a) to assess the continuity of popular mental health attitudes, and (b) to ascertain if experiences as a mental health services consumer had discernible impact on these attitudes. Given the context of massive changes over the past several decades in how mental health professionals, specifically, and society, in general, understand the nature of mental disorders, related changes in popular attitudes were expected. The most dramatic and far-reaching changes in the conceptualization and treatment of mental illness has been the great reduction of people housed in state mental institutions for long periods of time, often against their will. And as our society currently struggles within our political institutions to bring greater health care access to the entire population, the resulting changes are likely to importantly affect the entire mental health enterprise.

Within the foregoing context of change, the current study compared semantic differential and questionnaire responses of 472 Michigan college

students with two earlier U.S. and three New Zealand studies conducted over 30-plus years using parallel procedures.

The first two hypotheses were tested by examining the current data only. These hypotheses—that the public attaches stigma to the mentally ill but holds moderately favorable views of mental health professionals—directly parallel those tested in each of the earlier five studies. Both hypotheses were supported by the current findings. "Insane person," "mental patient," "troubled person," "doctor," "psychologist," and "psychiatrist" were all viewed as appreciably different than the "average person" by 1996 respondents. In general, "insane person," "mental patient," and "troubled person" were viewed as relatively unpredictable, dangerous, tense, and dirty, but "doctor," "psychologist," and "psychiatrist" were seen as relatively wise, clean, relaxed, and valuable.

Within each concept, post-hoc comparisons were performed on those semantic differential scale means that appeared to be rated differently by the 1996 respondents when compared to the composite mean difference of the five previous studies. Unfortunately, such analysis does not elucidate the nature of these differences. As shown in Table 3, certain bipolar scales, such as "valuable-worthless" have shown a consistent pattern of relationships to the other descriptors, while others, such as "rugged-delicate" have not (Green et al., 1987). On these latter type of scales, statistically significant findings may be an artifact of relatively lower scale intercorrelations. However,

differences shown in the more highly intercorrelated scales may reflect a real shift in attitudes. Future research might productively identify those semantic differential traits that are central to each concept's rating from those that are secondary. Such a study could be performed using a weighted semantic differential instrument that uses a ranking system for each scale. Another study that may elucidate the traits central to each concept's attitude structure would have participants provide written descriptions of each concept, then code the results.

Analysis of the concept "ex-mental patient" does not yield a clear interpretation of how such persons are perceived by the general public. In the current data only, a comparison between the mean of "ex-mental patient" and "average person" was the only such comparison that failed to achieve statistical significance. While one must tread cautiously in interpreting non-significant results, it is possible that "ex-mental patients" are not viewed all that differently than average people and may, in fact, be seen more favorably on some trait measures. However, the variability of 1996 responses to "ex-mental patient" may also have resulted from a less clear-cut definition of what an ex-mental patient is like.

The hypothesis that public attitudes toward the mentally ill and mental health professionals will become more favorable over the time period covered by these six studies (1962-1996) was not confirmed with respect to either the mental health professionals or the mentally disordered. In fact, there was

impressive similarity of responses across all six studies, as denoted by the high interstudy correlation coefficients across the 12 semantic differential scales. Nonetheless, the data suggest some interesting questions.

For example, the concept "psychologist" was added in the 1996 study to the original "doctor" and "psychiatrist" concepts to see how clearly the respondents differentiated among these three prominent "helping" professions. These college students viewed psychologists somewhat more favorably than psychiatrists but less favorably than doctors, although none of these differences were statistically significant. This may shed a bit of light on to the current debate among psychologists as to whether they want to be seen as similar to, or different from, their medical counterparts with respect to such issues as managed care or prescription privileges. If psychologists are perceived as being no different than psychiatrists, this prompts the question: To what extent do psychologists want to move closer to or away from the medical model?

Post-hoc analysis showed evidence for cross-cultural differences in the concept "psychiatrist," with New Zealanders viewing "psychiatrist" more favorably than Americans. It is possible such a difference is reflective of the relative status of psychiatrists in each country.

The most strongly stigmatized concepts—"mental patient" and "insane person"—showed remarkable attitudinal stability and notable structural similarity across the time period of these studies. The general public's

attitudes with respect to these emotionally charged concepts appear strongly resistant to change. What seems most striking about this particular inference is that attitudinal fixity continues despite widespread efforts in this country and elsewhere to "humanize" the mentally ill in the wake of wholesale deinstitutionalization. Those who seek to alter such attitudes at this level appear likely to encounter the proverbial "brick wall."

In contrast with the above, the 1996 sample's mean responses to the concept "ex-mental patient" were quite distinct from those of the previous U.S. and New Zealand studies and, like "psychiatrist," show evidence for cultural differences in attitudes. Across the 12 semantic differential scales, relatively low correlations ($Mdn r = .28$) were found when the 1996 data were compared to the previous studies. In addition, current responses to "ex-mental patient" did not reliably differ from those to "average person." This seems inconsistent with the maxim of "once a mental patient, always a mental patient." It seems that "successful" users of mental health services may be described quite favorably. It may be at this level where education efforts would be most effective.

The last two hypotheses examined whether experience with mental health professionals has a discernibly favorable impact on mental health consumers' attitudes. The aim was to find out more about the effects of mental health professionals' efforts, not only on the individual client, but on

society in general. The importance of greater knowledge in this area seems clear.

One step already taken in this direction was the recent publication of the Consumer Reports psychotherapy effectiveness study. This large survey concluded that while no one modality of treatment achieved consistently better results across disorders, patients nonetheless benefit substantially from psychotherapy (Seligman, 1995). Furthermore, Consumer Reports found that psychologists, psychiatrists and social workers are equally effective as therapists, faring better than marriage counselors or long-term family doctors. While the Consumer Reports survey focused on the individual effects of mental health treatment, the current study attempted to discern if these individual effects impact societal attitudes toward mental health professionals' efforts.

The hypothesis that experience with a mental health professional favorably impacts one's attitudes toward mental health professionals and persons viewed as mentally ill was not confirmed. It is, of course, possible that mental health professionals' efforts could have had undetected positive or negative effects.

Although this hypothesis was unconfirmed, a finding supportive of it deserves mention. Respondents who indicated that a family member or friend had sought professional help viewed the concept "insane person" more favorably than the other respondents. Other procedures would shed more

light on these findings. For example, family members of persons seeking in- and outpatient treatment could be asked to respond to concepts similar to those used in this study to determine attitudinal stability. Such family members could also be targeted to participate in educational programs designed to destigmatize people with mental disorders, and the results of such efforts could be measured.

The test of the last hypothesis considered only those respondents who reported a personal experience with a mental health professional ($n = 160$), divided into those satisfied or unsatisfied with the help they had received. This hypothesis was not confirmed except for the concept "psychologist," which was rated significantly more favorably by satisfied than by unsatisfied respondents. These findings can be interpreted by examining the proportion of respondents who were satisfied and those who were not. For example, for those respondents who indicated they saw a psychologist ($n = 68$), 69% reported they were happy with the help they received, while 25% said they were dissatisfied with such help. Among the other helping professions surveyed, the category "other" ($n = 12$), doctors ($n = 97$), and clergy ($n = 26$) received the highest ratings of satisfaction (83.3%, 81.5%, and 73.1%, respectively), while counselors ($n = 97$), social workers ($n = 24$), and psychiatrists ($n = 50$) received lower ratings of satisfaction (68.0%, 54.2%, and 50.0%, respectively).

There are several possible interpretations of these findings. Among the six helping professions surveyed, psychologists and psychiatrists are most exclusively concerned with mental health issues. It could be that psychologists may more often receive favorable evaluations of their efforts than by psychiatrists, as this study showed. In addition, to the extent that any given psychologist's therapeutic technique is theory driven (psychoanalysis versus behavior modification, for example), such therapists may choose to work with only those prospective clients whose presenting problems are a good "match" for their abilities. It would follow, then, that they might achieve a higher "success-to-failure" ratio (keeping in mind that "satisfaction" with therapists is not the same as "success" with therapists, although one would expect to find a relationship between the two).

Another inference is that the general public does distinguish between psychologists and the other helping professions and that psychologists, in general, are viewed more favorably. It makes sense, then, that one would be more likely to seek help from a mental health professional who was initially viewed more favorably and, therefore, more likely to be satisfied with that help.

Also, one can consider the role of doctors as referral sources for mental health treatment. This study showed that doctors received very high satisfaction ratings from mental health users (81.5%). (It should be mentioned, however, that it seems likely some participants gave favorable

marks to doctors for non-mental health problems.) If one goes to a trusted family doctor with a mental health concern and receives a referral (rather than treatment) that subsequently ameliorates the problem, one would likely hold both the referring physician and treatment professional in high esteem. If family physicians are more likely to refer one to a psychologist for psychotherapy versus referring to a psychiatrist for drug treatment (which could be done by the doctor him- or herself), this may help explain why some satisfied users of mental health services view psychologists more favorably than dissatisfied users. However, this study did not examine referral patterns of physicians for mental health services. One can only speculate as to how this variable affects service satisfaction and mental health attitudes. Such speculations deserve further research.

Finally, it is possible that because the participants in this study were enrolled in an introductory course in psychology, those who were mental health users had registered for this class partly because of their mental health experience, and, thus, may have been predisposed to view psychologists more favorably.

The current study addressed how contacts with mental health professionals impact mental health attitudes. Of particular interest to clinical psychologists is the finding that the current satisfied users of mental health services viewed psychologists more favorably than did dissatisfied users. As mentioned earlier, the Consumer Reports study found no such advantage.

Because the current study's statistical advantage for psychologists is so small, such results must be interpreted cautiously and demand verification.

APPENDICES

APPENDIX A

WORD-ASSOCIATION STUDY

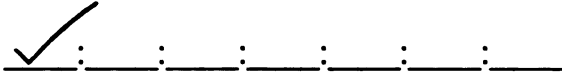
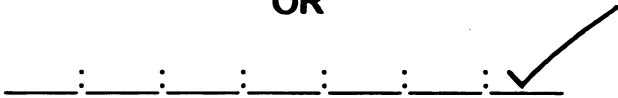
WORD-ASSOCIATION STUDY

You are being asked to participate in a study of word meanings. The object of the study is to find out how you like to describe different kinds of people. On the following pages are different people for you to describe. Your description can be made by marking the list of words on these pages. Take a look to see how this is done.

Each pair of words forms a scale. By making a check mark along the scale, you can indicate which words you associate with each particular kind of person.

If you feel that the person named is highly related with one end of the scale, you would place a check mark as follows:

Teacher

fair		unfair
OR		
fair		unfair

If you feel that the person is moderately related to one or the other end of the scale, you would place a check mark as follows:

Teacher

fair		unfair
OR		
fair		unfair

If the person seems only slightly related to one side as opposed to the other, you would place a check mark as follows:

Teacher

fair _____:_____:_____:_____:_____:_____:_____ unfair

OR

fair _____:_____:_____:_____:_____:_____:_____ unfair

If you consider both sides equally related, you would check the middle space on the scale:

Teacher

fair _____:_____:_____:_____:_____:_____:_____ unfair

Never put more than one check mark on any scale. Also, **be sure to check every item.** If you feel that a pair of adjectives does not apply to the person named or if you are undecided, place a check mark in the center space. Do not leave the line blank.

Do not spend more than a few seconds marking each scale. Your first impression is what is most important. You can work quicker if you first form a picture in your mind of the person mentioned, then check each scale rapidly.

Please do not put your name on this questionnaire. Thank you very much for your cooperation.

Doctor

valuable

worthless

insincere

sincere

cold

warm

fast

slow

delicate

rugged

tense

relaxed

clean

dirty

dangerous

safe

foolish

wise

strong

weak

predictable

unpredictable

complicated

simple

Psychiatrist

valuable

worthless

insincere

sincere

cold

warm

fast

slow

delicate

rugged

tense

relaxed

clean

dirty

dangerous

safe

foolish

wise

strong _____

weak

predictable _____

unpredictable

complicated _____

simple

Psychologist

valuable _____

worthless

insincere _____

sincere

cold _____

warm

fast _____

slow

delicate _____

rugged

tense _____

relaxed

clean _____

dirty

dangerous _____

safe

foolish _____

wise

strong _____

weak

predictable _____

unpredictable

complicated _____

simple

Most People

valuable _____

worthless

insincere _____

sincere

cold _____

warm

fast _____

slow

delicate _____

rugged

tense	_____:	_____:	_____:	_____:	_____:	_____:
clean	_____:	_____:	_____:	_____:	_____:	_____:
dangerous	_____:	_____:	_____:	_____:	_____:	_____:
foolish	_____:	_____:	_____:	_____:	_____:	_____:
strong	_____:	_____:	_____:	_____:	_____:	_____:
predictable	_____:	_____:	_____:	_____:	_____:	_____:
complicated	_____:	_____:	_____:	_____:	_____:	_____:

relaxed
dirty
safe
wise
weak
unpredictable
simple

Insane People

valuable	_____:	_____:	_____:	_____:	_____:	_____:
insincere	_____:	_____:	_____:	_____:	_____:	_____:
cold	_____:	_____:	_____:	_____:	_____:	_____:
fast	_____:	_____:	_____:	_____:	_____:	_____:
delicate	_____:	_____:	_____:	_____:	_____:	_____:
tense	_____:	_____:	_____:	_____:	_____:	_____:
clean	_____:	_____:	_____:	_____:	_____:	_____:
dangerous	_____:	_____:	_____:	_____:	_____:	_____:
foolish	_____:	_____:	_____:	_____:	_____:	_____:
strong	_____:	_____:	_____:	_____:	_____:	_____:
predictable	_____:	_____:	_____:	_____:	_____:	_____:
complicated	_____:	_____:	_____:	_____:	_____:	_____:

worthless
sincere
warm
slow
rugged
relaxed
dirty
safe
wise
weak
unpredictable
simple

Me

valuable	_____:	_____:	_____:	_____:	_____:	_____:	_____:
insincere	_____:	_____:	_____:	_____:	_____:	_____:	_____:
cold	_____:	_____:	_____:	_____:	_____:	_____:	_____:
fast	_____:	_____:	_____:	_____:	_____:	_____:	_____:
delicate	_____:	_____:	_____:	_____:	_____:	_____:	_____:
tense	_____:	_____:	_____:	_____:	_____:	_____:	_____:
clean	_____:	_____:	_____:	_____:	_____:	_____:	_____:
dangerous	_____:	_____:	_____:	_____:	_____:	_____:	_____:
foolish	_____:	_____:	_____:	_____:	_____:	_____:	_____:
strong	_____:	_____:	_____:	_____:	_____:	_____:	_____:
predictable	_____:	_____:	_____:	_____:	_____:	_____:	_____:
complicated	_____:	_____:	_____:	_____:	_____:	_____:	_____:

worthless

sincere

warm

slow

rugged

relaxed

dirty

safe

wise

weak

unpredictable

simple

Average Person

valuable	_____:	_____:	_____:	_____:	_____:	_____:	_____:
insincere	_____:	_____:	_____:	_____:	_____:	_____:	_____:
cold	_____:	_____:	_____:	_____:	_____:	_____:	_____:
fast	_____:	_____:	_____:	_____:	_____:	_____:	_____:
delicate	_____:	_____:	_____:	_____:	_____:	_____:	_____:
tense	_____:	_____:	_____:	_____:	_____:	_____:	_____:
clean	_____:	_____:	_____:	_____:	_____:	_____:	_____:
dangerous	_____:	_____:	_____:	_____:	_____:	_____:	_____:
foolish	_____:	_____:	_____:	_____:	_____:	_____:	_____:

worthless

sincere

warm

slow

rugged

relaxed

dirty

safe

wise

strong _____:_____:_____:_____:_____:_____:

weak

predictable _____:_____:_____:_____:_____:_____:

unpredictable

complicated _____:_____:_____:_____:_____:_____:

simple

Mental Patient

valuable _____:_____:_____:_____:_____:_____:

worthless

insincere _____:_____:_____:_____:_____:_____:

sincere

cold _____:_____:_____:_____:_____:_____:

warm

fast _____:_____:_____:_____:_____:_____:

slow

delicate _____:_____:_____:_____:_____:_____:

rugged

tense _____:_____:_____:_____:_____:_____:

relaxed

clean _____:_____:_____:_____:_____:_____:

dirty

dangerous _____:_____:_____:_____:_____:_____:

safe

foolish _____:_____:_____:_____:_____:_____:

wise

strong _____:_____:_____:_____:_____:_____:

weak

predictable _____:_____:_____:_____:_____:_____:

unpredictable

complicated _____:_____:_____:_____:_____:_____:

simple

Ex-Mental Patient

valuable _____:_____:_____:_____:_____:_____:

worthless

insincere _____:_____:_____:_____:_____:_____:

sincere

cold _____:_____:_____:_____:_____:_____:

warm

fast _____:_____:_____:_____:_____:_____:

slow

delicate _____:_____:_____:_____:_____:_____:

rugged

tense _____:_____:_____:_____:_____:_____:

clean _____:_____:_____:_____:_____:_____:

dangerous _____:_____:_____:_____:_____:_____:

foolish _____:_____:_____:_____:_____:_____:

strong _____:_____:_____:_____:_____:_____:

predictable _____:_____:_____:_____:_____:_____:

complicated _____:_____:_____:_____:_____:_____:

relaxed

dirty

safe

wise

weak

unpredictable

simple

Troubled Person

valuable _____:_____:_____:_____:_____:_____:

insincere _____:_____:_____:_____:_____:_____:

cold _____:_____:_____:_____:_____:_____:

fast _____:_____:_____:_____:_____:_____:

delicate _____:_____:_____:_____:_____:_____:

tense _____:_____:_____:_____:_____:_____:

clean _____:_____:_____:_____:_____:_____:

dangerous _____:_____:_____:_____:_____:_____:

foolish _____:_____:_____:_____:_____:_____:

strong _____:_____:_____:_____:_____:_____:

predictable _____:_____:_____:_____:_____:_____:

complicated _____:_____:_____:_____:_____:_____:

worthless

sincere

warm

slow

rugged

relaxed

dirty

safe

wise

weak

unpredictable

simple

APPENDIX B

EXPERIENCE WITH MENTAL HEALTH PROFESSIONALS

EXPERIENCE WITH MENTAL HEALTH PROFESSIONALS

Please take a few minutes to complete this questionnaire by answering a few questions about your experience with mental health professionals. Please place a check mark next to each appropriate item.

1. Age:

☐ 18 - 24	☐ 40 - 49	☐ 70 - 79
☐ 25 - 29	☐ 50 - 59	☐ 80+
☐ 30 - 39	☐ 60 - 69	

2. Sex:

☐ Male	☐ Female
-------------------------------	---------------------------------

3. Race:

☐ Asian	☐ Hispanic	☐ White
☐ Black	☐ Native American	

4. Mother's education level (check highest level of education completed):

☐ Grade school	☐ Trade/technical school
☐ Middle school	☐ Four-year college
☐ High school/GED equiv.	☐ Graduate school
	☐ Don't know

5. Father's education level (check highest level of education completed):

☐ Grade school	☐ Trade/technical school
☐ Middle school	☐ Four-year college
☐ High school/GED equiv.	☐ Graduate school
	☐ Don't know

6. Have you ever sought help from a mental health professional?

☐ Yes ☐ No (Go to Question 9)

7. If you answered "yes" to the above question, from whom did you seek help? (Check all that apply):

☐ Medical/family doctor ☐ Social worker
☐ Psychiatrist ☐ Clergy
☐ Psychologist ☐ Other: please specify _____
☐ Counselor

8. For each of the categories checked in Question 7, please rate your satisfaction with your **overall experience** with each mental health professional from whom you sought help:

Medical/family doctor: ☐ Very satisfactory
☐ Satisfactory
☐ Unsatisfactory
☐ Very unsatisfactory
☐ Uncertain

Psychiatrist: ☐ Very satisfactory
☐ Satisfactory
☐ Unsatisfactory
☐ Very unsatisfactory
☐ Uncertain

Psychologist:

- ☐ Very satisfactory
- ☐ Satisfactory
- ☐ Unsatisfactory
- ☐ Very unsatisfactory
- ☐ Uncertain

Counselor:

- ☐ Very satisfactory
- ☐ Satisfactory
- ☐ Unsatisfactory
- ☐ Very unsatisfactory
- ☐ Uncertain

Social worker:

- ☐ Very satisfactory
- ☐ Satisfactory
- ☐ Unsatisfactory
- ☐ Very unsatisfactory
- ☐ Uncertain

Clergy:

- ☐ Very satisfactory
- ☐ Satisfactory
- ☐ Unsatisfactory
- ☐ Very unsatisfactory
- ☐ Uncertain

Other:

___ Very satisfactory

___ Satisfactory

___ Unsatisfactory

___ Very unsatisfactory

___ Uncertain

9. Has either a family member, romantic partner, or close friend of yours ever sought help from a mental health professional?

___ Yes

___ No (You are finished; thank you for completing this questionnaire.)

10. If you answered "yes" to the above question, who is it you know that sought help from a mental health professional? (Check all that apply):

___ Mother

___ Spouse

___ Close friend

___ Father

___ Romantic partner

___ Sibling

___ Grandparent

___ Aunt/uncle

___ Cousin

___ In-law

11. For each family member, romantic partner or close friend checked above, please indicate which mental health professional each person visited and your impression of each's **overall experience** with each mental health professional. (NOTE: If any of the people checked above sought help from **more than one** mental health professional, please see the following example on how to complete the questionnaire):

EXAMPLE**Mother:**

☒ Family doctor	☐ Very satisfactory
☐ Psychiatrist	☒ Satisfactory
☐ Psychologist	☐ Unsatisfactory
☐ Counselor	☐ Very unsatisfactory
☐ (nonacademic)	☐ Uncertain
☒ Social worker	
☐ Clergy	
☐ Other (please specify): _____	

OR**Mother:**

☐ Family doctor	☒ Very satisfactory
☒ Psychiatrist	☐ Satisfactory
☒ Psychologist	☒ Unsatisfactory
☐ Counselor	☐ Very unsatisfactory
☐ (nonacademic)	☐ Uncertain
☐ Social worker	
☐ Clergy	
☐ Other (please specify): _____	

Continue completing questionnaire HERE: _____

Mother:	☐ Family doctor	☐ Very satisfactory
	☐ Psychiatrist	☐ Satisfactory
	☐ Psychologist	☐ Unsatisfactory
	☐ Counselor	☐ Very unsatisfactory
	☐ (nonacademic)	☐ Uncertain
	☐ Social worker	
	☐ Clergy	
	☐ Other (please specify): _____	
Father:	☐ Family doctor	☐ Very satisfactory
	☐ Psychiatrist	☐ Satisfactory
	☐ Psychologist	☐ Unsatisfactory
	☐ Counselor	☐ Very unsatisfactory
	☐ (nonacademic)	☐ Uncertain
	☐ Social worker	
	☐ Clergy	
	☐ Other (please specify): _____	
Sibling:	☐ Family doctor	☐ Very satisfactory
	☐ Psychiatrist	☐ Satisfactory
	☐ Psychologist	☐ Unsatisfactory
	☐ Counselor	☐ Very unsatisfactory
	☐ (nonacademic)	☐ Uncertain
	☐ Social worker	
	☐ Clergy	
	☐ Other (please specify): _____	

Grandparent: ___ Family doctor ___ Very satisfactory

 ___ Psychiatrist ___ Satisfactory

 ___ Psychologist ___ Unsatisfactory

 ___ Counselor ___ Very unsatisfactory

 (nonacademic) ___ Uncertain

 ___ Social worker

 ___ Clergy

 ___ Other (please specify): _____

Aunt/uncle: ☐ Family doctor ☐ Very satisfactory

☐ Psychiatrist ☐ Satisfactory

☐ Psychologist ☐ Unsatisfactory

☐ Counselor ☐ Very unsatisfactory

 (nonacademic) ☐ Uncertain

☐ Social worker

☐ Clergy

☐ Other (please specify): _____

Cousin:

☐ Family doctor	☐ Very satisfactory
☐ Psychiatrist	☐ Satisfactory
☐ Psychologist	☐ Unsatisfactory
☐ Counselor	☐ Very unsatisfactory
☐ (nonacademic)	☐ Uncertain
☐ Social worker	
☐ Clergy	
☐ Other (please specify): _____	

In-law:

☐ Family doctor	☐ Very satisfactory
☐ Psychiatrist	☐ Satisfactory
☐ Psychologist	☐ Unsatisfactory
☐ Counselor	☐ Very unsatisfactory
☐ (nonacademic)	☐ Uncertain
☐ Social worker	
☐ Clergy	
☐ Other (please specify): _____	

Spouse:

☐ Family doctor	☐ Very satisfactory
☐ Psychiatrist	☐ Satisfactory
☐ Psychologist	☐ Unsatisfactory
☐ Counselor	☐ Very unsatisfactory
☐ (nonacademic)	☐ Uncertain
☐ Social worker	
☐ Clergy	
☐ Other (please specify): _____	

Romantic partner:

☐ Family doctor	☐ Very satisfactory
☐ Psychiatrist	☐ Satisfactory
☐ Psychologist	☐ Unsatisfactory
☐ Counselor	☐ Very unsatisfactory
☐ (nonacademic)	☐ Uncertain
☐ Social worker	
☐ Clergy	
☐ Other (please specify): _____	

Thank you for answering these questions.

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