FACET ANALYSIS OF ATTITUDE - BEHAVIORS OF MENTAL PATIENTS TOWARD MENTAL ILLNESS IN A COMMUNITY MENTAL HEALTH CENTER

Dissertation for the Degree of Ph. D.

MICHIGAN STATE UNIVERSITY
BAHMAN DADGOSTAR

1974

This is to certify that the

thesis entitled

FACET ANALYSIS OF ATTITUDE-BEHAVIORS OF MENTAL PATIENTS TOWARD MENTAL ILLNESS IN A COMMUNITY MENTAL HEALTH CENTER

presented by

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has been accepted towards fulfillment of the requirements for

Ph.D. degree in Department of Counseling, Personnel Services, and Educational Psychology 1974

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Major professor

Date October 4, 1974

ABSTRACT

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By

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Problem and Purpose

Very little attention has been paid to the attitudes of people with emotional problems (the "mentally ill") toward emotional problems ("mental illness"), or to what these people consider emotional problems to be. What does a person who has been labeled as "mentally ill" call himself or herself, and what is the possible impact of the "mentally ill" on one another? Are they helpful or harmful to each other? These and other questions need to be answered.

The concept of mental health and mental illness has been interpreted by different cultures and by different schools of thought. Throughout history mentally ill people have been mistreated. The attitudes of people with emotional or mental problems toward mental (emotional) problems is an extremely important subject from the point of view of (a) social structures or social systems, from the point of view of (b) the conceptualization of mental health

and mental illness, and of (c) the development of treatment programs for mental health professionals and for others who work in the area, i.e., for the development of training and educational programs.

The major purpose of the present research was to investigate the attitudes of patients who had been referred to the Community Mental Health Center of the Ingham Medical Hospital,[1] and to assess the predictive validity of a set of hypotheses related to the attitudes of this group of patients before they receive any type of psychotherapy and after receiving treatment.

Methodology

The Attitude-Behavior Scale-Mental Illness (Emotional Problems)[2]-ABS-MI/EMO was administered to a group of patients who came to the Community Mental Health Center of the Ingham Medical Center in order to receive psychotherapy. The Attitude-Behavior Scale construction was guided by Guttman's facet theory of attitude structure and his definition of attitude as a "delimited totality of behavior with respect to something" (Guttman, 1950). According to the original theory of Guttman (1959), attitude was considered to be comprised of three facets and related elements, in such a way as to produce four levels of attitude-behavior. These four levels of

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[1]The name was changed to Ingham Medical Center while this research was being conducted.

[2]The terms mental illness and emotional problems are used in this study interchangably, as they refer to the same concept. Some people prefer to use the term mental illness while others prefer to use emotional problems. It depends on the model being used, i.e., the medical model uses the term mental illness, whereas the non-medical model uses the terms emotional problems or problems of living.

attitude-behavior represent a paradigm for interaction between or among groups. These four levels are: Stereotype, Normative Behavior, Hypothetical Behavior, and Personal Action. Guttman's theory was expanded into five facets and six levels by Jordan. These six levels contain the four which were identified by Guttman plus two additional levels: Moral Evaluation and Actual Feeling. The present study employed three levels (Normative, Moral Evaluation, and Feeling) of the six levels of Jordan's adaptation. A 38-item scale was used and each item was carried across the three attitude levels of Guttman-Jordan's paradigm. In addition the scales containing demographic questions were also used. The present investigation was based on a quasi-experimental research methodology using pre and post-test design.

Results

The results were obtained through the use of data analysis procedures which measured the affects of the following variables: psychotherapy, age, and education. Although the data did not indicate significant differences between pre-test and post-test results with regard to these three variables, it provided clues in the design of future investigations in the area of mental health and mental illness.

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A DISSERTATION

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

DOCTOR OF PHILOSOPHY

Department of Counseling, Personnel Services,
and Educational Psychology

1974

ACKNOWLEDGMENTS

I am indebted to many people for their support, assistance and interest. Foremost I am indebted to Dr. John E. Jordan who, as Chairman of my Doctoral Committee, guided me in the procedures of this investigation, from the initial stages through its completion. I would like to express my appreciation to Dr. James Costar, Dr. Alex Cade, Dr. Thomas Gunnings, and Dr. Pedro Ojeda for their interest, support, and suggestions.

I am grateful to Dr. Rom Kriauciunas, Chief Clinical Psychologist, and the rest of the staff of the Community Mental Health Center of the Ingham Medical Center.

I am very much indebted to the patients of the Community Mental Health Center for their cooperation. Completion of this research would not have been possible without their assistance.

Finally I am grateful to my wife and daughter for their unfailing encouragement and for their many sacrifices during this time.

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CHAPTER I

INTRODUCTION

The mental health movement is generally viewed as being concerned with the welfare and care of the mentally ill and the mentally handicapped. Organizations, state authorities, and professionals generally feel that the public should know more about mental health. This view has been particularly supported by different specialists in the field of medicine. The movement toward more emphasis on mental health programs is founded on two basic aspects: (a) mental illness and emotional problems, together with physical disease which effect the minds of individuals, produce limitations in emotional growth and compatibility with other human beings, and (b) mental and emotional problems not only affect the individual himself but also affect his close associates such as spouse and children as well as society in general.

From an historical point of view, the mentally ill have been viewed differently in many countries throughout history. Throughout history the mentally ill have been considered deviant and have aroused fear, revulsion, and disgust. Mentally ill subjects have been accused of devil possession. Therefore, disturbed people suffered from rejection, neglect, and even ill-treatment; psychotic people with possible

psychophysiological and psychochemical disorders were even punished for their "misbehavior."

The mentally ill have not been mistreated in all cultures. In some cultures some types of emotional problems, such as schizophrenia were viewed as a spiritual aspect. For example, in the Moslem world the "afflicted of Allah" have been traditionally given special consideration. There were hospitals in early times (12 A.D.) which were founded in Cairo and Baghdad. In the Hindu culture psychotic hallucinations were regarded as communication from the spirit world, the early Hindu societies showed remarkable tolerance for people with emotional problems and bizarre behavior.

In Christianity and Islam the belief of demon possession reached its height during the long preoccupation with witchcraft that coincided with the Reformation and Counter-Reformation.

One of the most interesting historical views is the attitude of ancient Jews toward mental patients. In the Hebrew ancient texts, one will see positive and accepting statements regarding attitudes toward mental illness. There is very little evidence in the Hebrew texts for an ostrasizing and intolerant attitude toward the mentally ill. The mentally ill was not ridiculed as being blessed in his illness, a state of affairs which would have justified abandoning the ill, leaving him untreated and suffering in order to preserve his blessedness or to retain him as a source of fun.

In the old Persian Zoroastrian culture (400 B.C.), mental problems were regarded as any natural disorder which man might possess, therefore psychotherapy as a science and practice was used as a major

aspect in the practice of medicine. The interesting point is the varied techniques and systems of psychotherapy which are used in different cultures and countries. In some cultures emphasis is placed on the biological basis of mental disorder, therefore they use both mental and physical methods with psychotherapy which are used in modern psychiatry and neurology.

Definitions of Mental Health and Mental Illness

Statements are often made such as "You are healthy," "I am sick," "He is disturbed." Who is normal, who is abnormal? Mental illness has been one of the major individual and social problems of society. Many professions and organizations as well as millions of people have discussed mental health and mental illness.

There are various ways of looking at the terms "mental illness" and "mental health." When there is a problem, i.e., not the usual normative situation, it is called "illness," which is viewed as the opposite of health. Increasingly, doubts are being expressed as to whether this is the right way of looking at it. Mental illness covers a wide range of phenomena, but is it all related to mental health? Does the loss of mental health end up with mental illness? Does recovery from mental illness mean the person is mentally healthy? These are the main questions which occupy the minds of specialists as they consider the use of the terms "mental illness" and "mental health." There is evidence that the dichotomy, mental health and mental illness, creates considerable confusion and contradiction when the behavior of human beings is observed in view of health and illness.

Mental health investigators, both experimentalists and theoreticians, are of the opinion that there should be universally accepted definitions, of mental illness and mental health; distinguishing one from the other.

The recent progress in the understanding and treatment of mental illness has been partly due to the opinion that mental illness is not an isolated phenomenon, but represents primarily a quantitative deviation from normality. It has been beneficial to de-emphasize the polarity of the terms mental illness and mental health and to stress possible differences between "states" of mental illness and mental health. The criteria of adequacy must be broken into at least two main components: (a) the individual's statements and expression of his/her own self, regarding his/her feelings and emotional experiences. For example, "I am happy," "I am feeling very well" and (b) social or public expectations, i.e., following standard social behavior.

Who is mentally healthy and who is not? When reference is made to a person as "mentally healthy" it does not mean that he does not have any problems. He may experience occasional depression and anxiety, but he is usually able to provide his own recovery. Mentally healthy persons are rarely seen by those who study mental illness.

A mentally ill individual, does not recover on his own. On the contrary, he is often unable to use help offered to him, he may also be resistent or in many cases will refuse to seek help.

In summary, mental health and mental illness are often seen as opposite poles of the same continuum. This polarization has resulted in confusion and contradictions. The causes of mental illness may be

biological (physiological, chemical, genetic, etc.) or psychological (developmental, family, early environmental factors, etc.). Since the general public associates many negative connotations with the term "mental illness"; many specialists in the field suggest utilizing the terms "emotional problems" or "problems of living (Szazz, 1968).

Many studies have shown (Whitman, 1970) that both patients and "normals" (i.e., persons in open society) see environmental problems and personality or behavioral disorders as the main causes of mental illness. However, while normal persons emphasized hereditary and organic factors to a greater degree, patients indicated interpersonal and behavioral difficulties more frequently. Patients ideas of etiological factors seem to be drawn from those prevailing in the larger culture.

Research studies have reported comparisons between cultures and their different definitions of mental illness. One of the best studies (Sydiaha, Lafave, and Roatmen, 1969) was done by a group of Canadian psychiatrists. In their investigation they sampled French and non-French within each of two communities. Lack of specific knowledge of mental illness tended to be associated with the minority elements in each community. Minority groups tended to have higher incidence rates of psychiatric disorders. Religious factors appeared not to be associated with incidence of mental illness. Stumme (1970) conducted a study to ascertain "what is meant by mental illness." The study reported that the common lay attitude toward the mentally ill indicates a general prejudice against the mental patient who is described as an uncontrolled, unpredictable, dangerous, violent, irresponsible person or an impulsive criminal. The result of this study revealed that the

term "mentally ill" is not synonymous with all types of mental disorder but in the eyes of the public is regarded as the most extreme deviation in behavior. The study also reported that the term "mentally ill" is usually associated with patients in mental or state hospitals rather than with a particular set of symptoms.

Since the definitions and conceptions of mental health is a very confusing subject, investigators try to formulate operational statements instead of defining mental health or mental illness. Klein (1960) suggests that the search for a definition of mental health be abandoned, at least temporarily, in favor of a differentiated approach to the problems of human adjustment and maladjustment. It has been suggested that the current concepts of mental health and mental illness are primarily concerned with the long standing emotional or psychological conditions of individuals for which the term "soundness" is proposed. The immediate state of "well" or "ill-being" of the individual at any particular time is proposed as suitable for more intensive study, both because of its possible effect on the soundness level in some instances, and because it should be considered in and of itself as a period of acute illness or malfunctioning and worthy of note in population studies. The susceptibility of the individual to environmental stresses may be considered as a general factor which may be a study for the future regarding the possible implications of child rearing and educational practices. Perhaps by following this more differentiated approach to mental health and mental illness we may find conflicting doctrines of today much less contradictory.

Nature of the Problem

The importance of research in the area of attitudes is a primary focus in much of social-psychological research. One of the major problems which exists regarding attitudinal research is how to measure attitudes. In general there are three main purposes for measuring attitudes: (a) to measure the nature and structure of attitudes and test hypotheses regarding the conditions under which different attitudes are created, (b) to study changes in attitudes, as this is considered to be the main focus of attitude research, and (c) to apply the findings of attitude research to the planning of new sources of services for the community. Namely, in order to service a community, one needs to know existing attitudes of that particular community.

There are many variables which are predictors of attitudes such as: sex, demographic information, education, religion, social, psychological, economic, socio-economic, and contact (amount and quality). One of the major benefits of knowing existing attitudes in the field of mental health is the matter of prevention.

An ounce of prevention may cost a pound of cure. Primary prevention has been a key element in the ideology of the community mental movement over the past ten years (Shulberg and Baker, 1969). Many scholars in the field of community mental health have placed strong emphasis on the importance of adopting a public health approach to the widespread prevalence of mental illness and have emphasized the necessity for preventive intervention (Caplan, 1964, 1970). Unfortunately the prevention emphasis has not always been accepted and the

public did not try to get involved in it due to the idea that the major purpose of the mental hygiene movement was the curbing of the growth of illness. This rejection of the public health model grew after disillusionment and failure of the earlier mental hygiene movement in curbing the growth of mental illness. The prevention approach gained acceptance when consultation education was accepted as one of the essential services of community mental health centers. Since 1963 there have been considerable writings and research devoted to consultation education as a primary method of prevention (N.I.M.H.).

Despite such efforts, however, according to reports of the National Institute of Mental Health (N.I.M.H., 1971a, 1971b), mental health agencies know the importance of primary preventive but they continue to devote their major resources to the treatment, diagnosis, and rehabilitation, and neglect to emphasize the importance of intervention.

Many investigators have pointed out the barriers to primary prevention. One barrier of primary prevention is the resistance of people because they feel that nothing can be done short of a major overhaul of society (Bower, 1961, 1965). Bower has suggested that society will usually resist specific strategies as an invasion of privacy, therefore they are cautious about primary prevention. Bower also indicates that preventative efforts have a lower professional status than treatment, diagnosis, and rehabilitation. Snoke (1969) also stated that public health in general has a lower status when compared with the "curative program." Another important barrier of primary preventions, as indicated by Rieff (1967), is the lack of

trained specialists to carry out primary prevention activities. This idea has been emphasized by other investigators who indicate that the lack of trained specialists is because people are more inclined to be trained in the area of treatment and rehabilitation rather than primary prevention due to its lower status importance. Broskowski and Khajavi (1973) and Broskowski and Baker (1974) identify other barriers such as the fact that primary prevention is explained in a medical illness model rather than by an emotional and social psychological model. The idea of medical vs. non-medical models has been discussed by many psychiatrists and psychologists. Szasz (1961) soundly criticizes the medical model in discussing mental problems and mental illness. He even refuses to use the term mental illness, rather using the term: "problems of living."

The medical model obscures the "value goals" of psychotherapy and the social goals of social psychiatry and social psychology. The ultimate goal of psychotherapy is individual self-knowledge and self mastery that fits within the constraints of society but does not become closed to changing the society. Expressing these goals in the language of medicine confuses the public about the nature of the human problem called mental illness. It obscures the relationship of these problems to the nature of the social order and it forces the public to rely on experts rather than on its own store of human wisdom. Therefore psychiatry is under attacks to abandon its medical disguise since it has been labeling people with psychophysiological and psychobiological problems as mentally ill rather than also seeing the social system as a primary factor in a particular set of "human problems."

The deviant person is determined by social labeling rather than by objective and behavioral criteria. Szasz (1961) suggests that the phenomenon which is called mental illness be removed from the category of illnesses and be regarded as an expression of man's struggle with the problem of how he should live and how he interacts or relates with others and himself.

Statement of the Problem

Of the studies related to the present study, Maierle (1967) and Whitman (1970) relate directly to the use of the Guttman-Jordan (1968) theory used in this research. The general prupose of the present study was to investigate attitudes of mental patients or people with different degrees of emotional problems who have never been to any type of psychotherapy before, toward mental illness. The specific delimited purpose of the study was to test attitudes toward emotional problems, before and after psychotherapy, of subjects with no previous experience with psychotherapy.

The subjects of the present study were clients of the Ingham Medical Center, Community Mental Health Center. As detailed in the chapter on results in this study, a need exists for additional attitude research designed to promote knowledge of both substantive and methodological aspects.

The patients attitudes were measured by a "set" of Guttman-Jordan facet theory derived scales: Attitude-Behavior Scale: Emotional Problems/Mental Illness-ABS-EMO or ABS-MI.

The specific purposes of the present study were:

1. Ascertain attitudes toward "mental illness," of people with emotional problems when they first come to the Community Mental Health Center and after they are treated at the Center. In other words, to measure value orientations and attitudes toward mental illness of non-institutionalized mentally ill or people with emotional problems.
2. To assess predictive validity of the following hypothesized determinants of attitudes toward mental illness; demographic, valuational, and contact.
3. To use the Guttman-Jordan facet theory scaling approach on a population of patients who have never had psychotherapy, before and after treatment.
4. To test the Guttman facet theory hypothesis that, according to the principle of contiguity, the matrix of correlations will approximate a simplex (Guttman, 1959, 1966; Jordan, 1968, 1971).
5. To develop plans to replicate the study in Iran regarding the attitudes of mentally ill or people with emotional problems toward mental illness.
6. Ascertain relationships among varieties of attitude-behaviors, before and after psychotherapy, and relationships between designated predictor variables regarding attitudes toward mental illness (e.g., sex, education, religion, age).

7. Provide evaluation data for the out-patient program of the Ingham Medical Center, Community Mental Health Center, which could be feedback as a basis of decisions regarding future program plans.

The knowledge attained through the above mentioned purposes may ultimately permit greater understanding and prediction of the kinds of attitudes, experiences, and situations which promote negative or positive behavior of people toward mental illness. In addition to the applied knowledge gained there are other potential benefits regarding the structure and measurement of attitudes.

CHAPTER II

REVIEW OF THE LITERATURE

In numerous studies on hospitalized patients, mental and non-mental patients, it was found that mental patients are no better informed about mental illness or mental health than other people. Their attitudes toward mental illness were found to be as negative as other people (Givannoni and Ullman, 1963). In another study conducted by Crumpton and Wine (1965) it was concluded that differences exist between schizophrenic and non-mental patients in their conceptions of normality and mental illness. The differences could not be ascertained with certainty, but there were some points of argument which can be followed in this study.

The Psychiatry Digest (May, 1965) reported that non-mental patients say the mental patient is sick; the schizophrenic says that the mental patient is not sick, he is immoral. The non-mental patient thinks that the mental patient is dangerous, but the schizophrenic considers him safe. Non-mental patients say a man can be neurotic or show some neurotic behavior due to pressures of life, or, social-psychological situations, but a schizophrenic person does not know what "normal" (free from mental illness) is, and probably considers himself "normal."

Perhaps the most systematic series of studies of popular concepts of mental health and mental illness and the effects of the mass media in communicating information about mental health and mental illness have been those of Nunnally and his associates (1961). Nunnally investigated both information, i.e., knowledge of the facts held by the general public, and public attitudes or feelings, where no question of truth or falsity was involved. He found that the average man is not grossly misinformed, but rather he is uninformed about many issues. This, Nunnally stresses, is an important distinction since it is easier to supply new information than to change well established opinions.

On the other hand, public attitudes are relatively negative toward persons with mental health problems, with those suffering from psychotic disorders being held in lower esteem than those with neurotic disorders. While the younger and more educated have more information than the older and less educated, there is little difference in their attitudes toward the mentally ill. By contrast the public holds moderately high positive attitudes toward mental health professionals, though it places a higher evaluation on those who treat physical disorders. Nunnally and his associates found that the general practitioner tends to be the "gate keeper" for the mentally ill, and that 77 percent say they treat about half of the mental patients they see. The general practitioners also tend to have a negative attitude toward the mentally ill and a moderately favorable attitude toward mental treatment specialists, hospitals, and mental institutions. Again, the younger and better informed

physicians tend to have more favorable attitudes and are more prone to treat mental problems than refer these patients to specialists.

This may be explained in part by their questioning of psychiatric treatment, though they express high regard for Psychiatrists as professionals. A major aspect of the Nunnally study is its report on the process of information transmission and attitude change. In the study of public interest about mental health topics they found that mental health topics compete well with other subjects in the mass media, but in general the public interest is centered on the immediate personal aspects of mental health problems (e.g., what causes them? how can one recognize them?), with rather low interest in broader problems relating to mental heatlh (e.g., the cost of mental illness to the community).

Nunnally's research thus made a significant contribution to the understanding of variables which influence the transmittal of mental health information. It seems also by inference to throw further light on the "closed ranks" phenomenon experienced by Cummings (1957) when he attempted to study mental health education. Briefly, Nunnally investigated the opinions and attitudes that normal subjects held concerning mental health and mental illness. He concluded that the information held by the public is not really "bad" in the sense of being misinformed, but that the attitudes held by the public are fairly negative.

A subject which has attracted the attention of many professionals in the area of psychotherapy is the influence of attitudinal factors on treatment. One of the better studies was done by Brady,

Zeller and Reznikoff (1955). The general favorableness of the patient's attitudes toward psychiatric hospitals, psychiatrists, and psychiatric treatment was investigated. A favorable attitude toward mental illness, which seemed to be somewhat independent of background factors such as age, occupation, sex, etc., was found to be significantly related to successful outcomes of treatment. A favorable response to treatment was associated with the tendency to perceive, at the start of treatment, the psychotherapeutic stiuation as a neutral rather than a distinctly pleasurable experience. This study indicated that background factors such as age and previous treatment or psychotherapy bear some relationship to patients' attitudes.

Gunther and Brilliant (1964) studied the attitudes of psychiatric patients toward mental illness to determine if attitudes were related to degrees of psychopathology. Another purpose of their study was to assess the effects of demographic variables such as sex, age, and education on attitudes toward mental illness. The results of their study indicate that successful treatment was not related to sex or admission status. However, they were related to age, education, and marital status. The data indicated that the older, married, and less educated patients were more custodial in their orientation toward mental illness than the younger, unmarried, and more educated patients. Further, a significant relationship was found between degree of psychopathology and attitudes toward mental illness, the more emotionally disturbed patients usually expressed a more humanitarian ideology. There are many investigations such as those of Rosenthals (1955) and Manis, Houts, and Blake (1963) which

relate attitude change to progress in treatment. Those patients who improved in psychotherapy (as rated by external observers) tended to adopt the value systems of their therapists concerning sex, aggression, and authority; patients who did not improve became less like their therapists. These studies point to the importance of the therapeutic relationship and "modeling" to treatment outcomes.

Crumption, Weinstein, Acker, and Annis (1967) conducted a study to ascertain how patients and normals view the mental patient. Their data indicated that normals view mental illness as a sickness or a dangerous state while patients' views are colored by moral terms. This study has been supported by other studies such as Crumpton and Wine (1965); Giovannoni and Ulman (1963); Manis, Houts, and Blake (1963); and Nunnally (1961). In summary, these studies indicate that the mental patient is described in unfavorable terms such as excitable, foolish, unsuccessful, unusual, slow, active, weak, lazy, cruel, and ugly. Ratings of the "mental patient" were somewhat more likely to resemble ratings of "sick person" and "dangerous person" when made by normals, and more likely to resemble ratings of "criminal" and "sinner" when made by patients.

Jones, Kahn, and McDonald (1963) studied the views of psychiatric patients toward mental illness, hospitalization, and treatment. The type of questions which were asked were grouped into areas of attitudes in the following scheme: (a) conceptions of illness, (b) stigma of hospitalization or illness, (c) conceptions of hospitalization and treatment, and (d) attitudes toward hospital activities and treatment. The study indicated that patients show

considerable understanding of mental illness. Perhaps recent educational campaigns about mental illness have had widespread acceptance and effect on the public. The results of the study by Jones, Kahn, and McDonald (1963) suggest that the methods developed in the study are promising procedures for describing patients' views and for comparing patients' attitudes toward hospital goals.

Finally, it has been demonstrated that, under certain circumstances, what a person reportedly says about himself significantly influences the interpretation of his behavior by another, even though the behavior does not justify that interpretation. It has also been postulated that the type of contact a person has with mental problems affects his attitudes. Farina and Ring (1963), in their study about the influence of perceived mental illness on interpersonal relations, stated that if contact has been prolonged and intimate, it is reasonable to suppose that one's interpretation of another's behavior would be based less on stereotypes and more on the behavior itself. But during the initial phases of an interpersonal interaction one's interpretation of another's behavior tends to be based on stereotypes, and therefore, precisely because of these distortions in perception, further interpretation of the kind necessary to eradicate such stereotypes is not likely to occur. These statements have been the subject of arguments by many specialists in the area of attitude research.

The mental illness paradigm, as a model for understanding and controlling deviant conduct, has not been widely accepted by the public. The central objective of the mental health movement has been

to influence the general public to regard mental illness with the same non-rejecting valuations as somatic illness. The reports of many researchers have shown that the public tends to project negative (rejection) valuations on persons diagnosed as mentally ill. On the other hand, the public tends to be more tolerant of deviant conduct when it is not described with mental illness labels.

In other studies, attitudes toward mental illness are considered to be an element in the environment. Human beings appear to be capable of evaluating behavior patterns differently at different times and in different situations.

Many people have expressed, at least verbally, sentiments of understanding and tolerance for the mentally ill. Some social-psychological studies have reported that the public is presenting evidence of an emerging ability to distinguish between social deviation, i.e., behavior determined by socio-cultural factors, and mental illness. To the extent that this is true, the sociology of deviant behavior would no longer apply to the universe of mental illness as it has in the past (Lemkau and Crocetti, 1962).

A survey was conducted in Baltimore, Maryland (Lemkau and Crocetti, 1962) using a randomly selected sample of the population in order to study public information and attitudes toward mental illness. The results differed substantially from those attained in similar studies using identical or similar questions and comparable methodology. The most striking contrast was that the majority of respondents of the present study identified each of the following three descriptions of behavior as indicative of mental illness: (a) that of a simple

schizophrenic, (b) of a paranoid, and (c) of an alcoholic (these descriptive stories have been used in previous studies, in which the only one recognized as mentally ill my a majority of the respondents was the aggressive paranoid). Thus, the present study showed no tendency on the part of the public to deny mental illness. The study also showed no tendency toward attitudes of pessimism or defeatism in the face of intensified mental illness, and there was no tendency for the respondents to isolate or reject the mentally ill. The results of this investigation seem to indicate that attitudes toward mental illness are changing. Although it has been argued that the increased ability of the public to identify mental illness may lead to greater acceptance of the mentally ill, it is also suggested (Phillips, 1967) that the opposite may be true. To explore this position a pilot study was done in a small New England community (Lemkau, 1968). Data were collected from interviews with a random sample of 86 adults. It was found that the ability to correctly identify behavior as mental illness is associated with rejection, not with acceptance.

In another study (Bohr and Hunt, 1967) a factor analytic analysis of the opinion of psychiatric patients about mental illness was conducted. The factorial structure of staff members' opinions about mental illness, as described in an earlier study, was compared with that of hospitalized psychiatric pateints. Most of the patients were blue-collar workers with little education. Differences were found between the cognitive organization of mental illness attitudes by

staff members and by patients. The primary factor among the staff members was authoritarianism, whereas the first factor among the patients was denial, thus reflecting (a) their discovery of the severity of mental illness, (b) a non-psychological attitude toward life, and (c) a positive orientation toward social mobility and work. The results of this study suggest that hospitalized blue-collar patients, in contrast with mental health professionals, hold negative attitudes toward mental illness that are typical of the public in general and specifically of the lower strata of society. Therefore, it was concluded that a close relationship existed between social systems, general social-psychological attitudes and mental health ideology (Bohr and Hunt, 1967).

Several studies have examined relationships between different strata of society and social status. Dohren, Wend, and Chin-Shong (1967) studied the attitudes of community leaders toward psychological disorder in contrast to attitudes held by an ethnic cross-section in an urban area. Results indicated that the general public is more likely now than in the 1950's to use the label "mentally ill" when describing deviant behavior, thus bringing the public view more in line with that of mental health professionals. Differences between psychiatrists (mental health professionals) and the general public emerged in judgments about the seriousness of problems. The general public does not judge seriousness on the basis of severity of psychopathology, as do psychiatrists or other mental health professionals such as psychologists, counselors or social workers, but on the basis

of the magnitude of overt threat to others. Concern about sociopathic forms of deviance was inversely related to social class. This appearance of greater tolerance in low-status groups seems to be a consequence of their generally more accepting orientation toward deviance, in contrast with high-status groups which seem to be less conducive to accepting deviance and less receptivity to humanistic attitudes toward mental health.

One of the major interests of scholars is the mental health of a community and the attitudes of that community toward mental illness. Perhaps the most underestimated problem facing our society today is that of the treatment of emotionally disturbed people. Unenlightened attitudes toward mental illness, rising suicide rates, and alcohol and drug addiction all point to an unwillingness and perhaps an inability to cope with the stresses of modern society. The manifestations of a disturbed society, as with a disturbed individual, are best treated early in the development of the disturbance. Therefore, it is urgent that more attention be paid to the emotional welfare of the young portion of society. By such procedures one can hope to provide future society with a better adjusted adult population. To accomplish this the stigma of mental illness must be removed and people must get involved in helping other people (Henley, 1968).

In one study (Freeman, 1961) attitudes toward mental illness among relatives of former patients was investigated (the patients were mostly schizophrenic). A conclusion of this study was that "enlightened" attitudes toward mental illness were found to be positively correlated with level of formal education and verbal ability, and negatively

correlated with age. This study suggests that enlightened attitudes toward mental illness can be parsimoniously accounted for on the basis of differential verbal skills rather than on the basis of differences in "style of life." This study also reported that the relative's attitudes were not related to the diagnosis of the patient's illness nor to the duration of hospitalization. The patients' past hospital behavior seemed to influence the attitudes of family members, regardless of their education level or age. Attitudes of patients' relatives seemed to be rooted in a set of diverse elements that include socialization as well as situational variables.

The results of another study (Ellsworth, 1965) lend support to defining attitude as an underlying disposition which enters into the determination of a variety of behaviors toward an objective class of objects, including statements of belief and feelings about the object as well as one's actions with respect to it (Cook and Selltiz, 1964). A measure of one's responses to an attitude questionnaire does not represent a complete measure of one's underlying attitude. Studies which report that student nurses change significantly in their attitudes as a result of psychiatric affiliation (Giford and Ullman, 1961, and Hicks and Spaner, 1962) are basically reporting a change in the manner in which the student nurses responded to a set of attitude statements toward mental illness. One cannot assume that a basic or underlying attitude change has indeed taken place unless one also knows the extent to which there has been a parallel change in the relationship between the student nurse and the hospitalized patient.

The relationship between the attitude of a staff member toward mental illness and his rated effectiveness in a hospital setting is dependent upon several factors. In a study by Taomey, Reznikoff, Brady, and Shuman (1961) no relationship was found between verbally expressed attitudes and success in psychiatric affiliation.

The final conclusion about the relationship between expressed attitudes and effectiveness in patient rehabilitation will undoubtedly depend on what attitudes are being measured, the kind of demands of the treatment situation itself, and the kind of patient being treated.

Facet Theory Attitude Research

Throughout history behavioral scientists have employed different techniques to measure and categorize human feelings, thoughts, beliefs, and action; which can all be viewed as different aspects of behavior. The techniques and methods of measurement are classified into three general areas: (a) observations of individual and group behavior which are concerned with viewing, analysis, and description of behavior, (b) self-report via which the subject reports to the investigator his thoughts, feelings, actions, and beliefs, and (c) the use of an external methodological procedure, such as a scale, to measure human behavior. Self-report is especially useful in the fields of psychology, psychoanalysis, and in the Gestalt approach. A combination of the last two techniques was used in Jordan's attitude-behavior research program and the series of scales devised from it (Hamersma, Paige, and Jordan, 1973; Bray and Jordan, 1973; Jordan, 1970; Poulos, 1970; Matthews, 1975; Gottlieb, 1973; Whitman, 1970;

Down, 1974; Smith, 1973, 1974; Bray, 1974a, 1974b). The Attitude-Behavior Scale is a self-report instrument which measures an individual's self reported feelings, thinking, and actual behavior. This chapter comprises a summary of both Guttman's original formulation and the subsequent adaptations and developments proposed by Jordan.

Quantitative vs. Qualitative

One of the main problems of research, particularly in the field of behavioral studies and social sciences, is the goal of adequately quantifying the qualitative. In the area of attitude-behavior it is extremely difficult to measure those aspects of human behavior which are qualitative rather than quantitative.

The research literature contains two main definitions of attitude. The first definition denotes attitudes as a "predisposition to behavior," and the second approach defines attitudes as "behavior" itself. Guttman (1950, p. 51) defined attitudes as a "delimited totality of behavior with respect to something." Jordan (1971) states that attitude and behavior cannot be separated from each other. An attitude must be considered as a whole or a totality. There are many other investigators who have defined attitude. In the early part of the 20th century social scientists started propounding definitions of attitudes, most of which emphasized the cognitive and motor aspects of attitudes. The three classical definitions of attitude during this period, which have been cited by Allport (1954, p. 45) are the following: (a) Attitude is the specific mental disposition toward an incoming (or arising) experience, whereby that experience is

modified, or a condition of readiness for a certain type of activity (Warren, 1934); (b) An attitude is a mental disposition of the human individual to act for or against a definite object (Drola, 1933); Finally, Allport himself defined attitude in psychophysiological and bio-social terms as (c) A mental or neural state of readiness, organized through experience, exerting a directive or dynamic influence upon the individual's response to all objects and situations with which it is related (Allport, 1935).

The Guttman-Jordan theory considers attitude as a whole or a totality, a universe, composed of interdependent parts in which the parts themselves are subdivided and rearranged in specified diverse ways to represent the totality. It is this unique concept of totality and its ordered components as applied to "attitude-behavior" that enable scientists to quantify qualitative data. Facet theory is therefore a type of "set" theory. All the possible combinations of the diverse elements in a set are called the "set product" or "Cartesian product" (Elizur, 1970). In facet analysis, the combination of the elements across a total set, i.e., a profile, may be viewed as a multivariate instrument which has many variables, aspects, qualities, or facets. Two basic principles arise from the discussion of set theory. The first is the "rationale" which is imposed upon the selection and specification of the basic sets which are called facets. And the second is the method of "ordering" the variables selected for study in the attitude-behavior universe.

Guttman (1954) divided factor analysis into two basic types: (a) the method of "common factors," which is the approach used by

Spearmen, Thurstone, and others, and (b) the method of "order-factors" which Guttman considers his own approach. Guttman does not make a complete differentiation between these two methods of research, but as mentioned before, he considers factor analytic techniques as the predecessor of facet theory. Guttman's approach to research methodology is primarily motivated by psychological, sociological or social psychological considerations, rather than those of factor analysis which are basically mathematical in nature.

In the Guttman-Jordan type attitude-behavior scales two major aspects are considered: (a) the domain of the behavior which may be cognitive, affective, or instrumental, and (b) a common range, which is ordered from very positive to very negative towards that object. From the above statement, Guttman develops the "First General Law of Attitude" which states that, "If any two items are selected from the universe of attitude items toward a given object, and if the population observed is not selected artificially, then the population regressions between these two items will be monotone and with positive or Zero Sign" (Gratch, 1973).

The value of research is based on the validity and reliability which is imputed to the techniques and instruments of the study. These are the two elements which are specifically considered in facet theory. Since the major goal of Guttman-Jordan's attitude facet theory is to quantify qualitative data, facet theory purports to construct an instrument which can measure attitude-behavior or the qualitative aspects of behavior. The strength of the Guttman-Jordan porpositions are: (a) its logical and empirical relevance, and (b) the precision of its

"ordering principle" which introduces the concept of semantic structure as a procedure to quantify qualitative data (Foa and Turner, 1970).

Four-Level Theory

If one accepts Guttman's definition (1950, p. 51) of attitude as "a delimited totality of behavior with respect to something," then both verbal reactions and overt behavior can be regarded as attitude. If the attitude responses are properly categorized then the individual responses can be analyzed in an ordered arrangement. Ordered elements within semantic factors are one of the ways which facilitate measurement.

In a reanalysis and review of the research by Bastide and Van den Berghe (1957), Guttman (1959) isolated three "necessary" semantic factors which may be involved in an attitude response and which can be combined according to definite procedures to determine the element structure of eight important profiles. In Guttman's approach one element from each facet of Table 1 must be represented in any attitude statement. The multiplication of these 2 x 2 x 2 facet combinations produce an attitude universe of eight semantic profiles: (1) $a_1\ b_1\ c_1$, (2) $a_1\ b_1\ c_2$, (3) $a_1\ b_2\ c_2$, . . . (8) $a_2\ b_2\ c_2$.

Guttman's three semantic factors were: (a) the Subject's behavior which consists of belief and overt action, (b) the Referent: group or self, and (c) the Referent's intergroup behavior (comparative or interaction). Each of the above facets contained two elements: one weak and one strong element in each of the three facets. Guttman proposed the "mapping sentence" as a procedure to develop a faceted

TABLE 1.--Basic Facets Used to Determine Component Structure of an Attitude Universe.

(A) Subjects Behavior	(B) Referent	(C) Referent's Intergroup Behavior
a_1 belief	b_1 subject's group	c_1 comparative
a_2 overt action	b_2 subject himself	c_2 interaction

TABLE 2.--The Four Combinations and Descriptive Names Used in Guttman's Four Level Facet Theory.

Level	Profile	Descriptive Name
1	a_1 b_1 c_1	Stereotype
2	a_1 b_1 c_2	Normative
3	a_1 b_2 c_2	Hypothetical Interaction
4	a_2 b_2 c_2	Personal Interaction

TABLE 3.--Basic Facets Used to Determine Joint Struction of an Attitude Universe.

Referent	Referent Behavior	Actor	Actor's Intergroup Behavior	Domain of Actor's Behavior
a_1 others	b_1 belief	c_1 others	d_1 comparison	e_1 symbolic
a_2 self	b_2 action	c_2 self	d_2 interaction	e_2 operational
(I)	(overt action)	(mine/my)		

semantic definition of a particular attitude research problem. Guttman provided logical reasons for considering four permutations of strong-weak elements from the Bastide and van der Berghe research. Elements can be ordered within the facets and the facets can be ordered with respect to each other. An ordered analysis of the semantic factors could then be established which will yield N + 1 types of attitude levels. Each succeeding level contains one more "strong" element than the preceeding one.

Guttman (1966) hypothesized that if the items are organized in accordance with the four levels, then the levels closest to each other are similar to each other, and are more highly correlated with each other than levels which are more distant from each other. According to Guttman, then the responses to Level 1 should be more similar and more highly correlated with the items and questions of Level 2. Guttman refers to this statement as the "principle of contiguity." By this he means that items that are closer semantically should also be closer statistically. By the principle of contiguity Guttman devises the "simplex" notion. A simplex is a matrix of level-by-level correlations in which the order of the correlations is specified. This simplex hypothesis has been supported by Guttman's own research (1961) and other investigators (Foa, 1958, 1963; and Jordan, 1968, 1971).

Guttman's facet proposal is to construct a scale by semantic procedures in order to predict the order of that structure from empirical data. In comparing facet theory with factor analysis one will find that facet theory and Guttman's methodology is the reverse

of what factor analysis does. Factor analysis tries to interpret the mathematical outcomes in a descriptive scheme, making correlational statements between what are called factors. Facet theory specifies the factors or "facets" before the data are gathered. Then the hypothesis is tested empirically in order to determine the relationship between the hypothesized semantic structure and the obtained statistical structure.

Six-Level Adaptation

It has been felt by some investigators (Jordan, 1968) that the Guttman attitude facets needed to be extended. Jordan (1968) expanded Guttman's attitude facets to include five facets and six levels. Table 3 contains the facets and elements developed by Jordan.

Table 3 indicates the five/two-element/facets which produce 32 possible combinations of elements or profiles (Maierle, 1969). The joint struction of Table 3 is actually defined as the ordered sets of the five facets; low subscript 1's to high subscript 2's for all five facets. Namely, low indicates a cognitive-other-passive orientation while high indicates an affective-self-action orientation (Jordan, 1968, 1971).

Table 5 contains the six profiles that were chosen as psychologically relevant, potentially capable of instrumentation, and possessing a specific relationship between themselves: a simplex one.

In Table 5 joint struction refers to the combinations of facets A through E. Table 5 illustrates the order of the attitude levels; namely 1 < 2 < 3 4 < 5 < 6 or Social Stereotpye < Societal

Norm < Personal Moral Evaluation < Personal Hypothetical Action < Personal Feeling < Personal Action. Each of these profiles is a "deliminated totality of behavior." Guttman indicates that an ordering by facets also implies an ordering within each facet. In this case the ordering of 1 < 2 < 3 < 4 < 5 < 6 implies also the following ordering: $a_1 < c_2$, $b_1 < b_2$, $c_1 < c_2$, $d_1 < d_2$, . . . $x_1 < x_2$.

Attitude content is called "lateral" struction. The lateral struction deals with the content of the items and is very much related to the specific situation or attitude object. Figure 1 has been adopted from Harrelson (1970) in order to illustrate a mapping sentence and five additional facets which show the item content or lateral struction. This table also illustrates the relationship between joint struction or lateral struction on the ABS-MR (Attitude-Behavior Scale-Mental Retardation).

The six facets of Table 3 are defined by Jordan (1968, 1971) as follows:

Facet A - the referent "other" is weaker than "self"--I in being less personal.

Facet B - "belief" is weaker than "action" in being passive rather than being active.

Facet C - referring to the behavior of one's "self"--mine/my rather than of "others" is stronger in that it implies personal involvement.

Level	Facet Profile	No.[a]	Definitional Statements[b]	Descriptive Term[c]
1	$\frac{o\ b\ o\ c\ h}{a_1 b_1 c_1 d_1 e_1}$	0	Others believe others' comparisons hypothetically	**Societal stereotype (group assigned group status)
2	i b o c h	1	I believe others' comparisons hypothetically	Personally-assigned group status
	$\frac{o\ b\ o\ i\ h}{a_1 b_1 c_1 d_2 e_1}$		Others believe others' interactions hypothetically	**Societal norm
	o b m c h		Others believe my comparison hypothetically	Group-assigned personal status
3	$\frac{i\ b\ o\ i\ h}{a_2 b_1 c_1 d_2 e_1}$	2	I believe others' interactions hypothetically	**Personal moral evaluation (perceived values)
	i b m c h		I believe my comparisons hypothetically	Self-concept (personally-assigned personal status)
	o b m i h		Others believe my interactions hypothetically	Proclaimed laws (groups expectations)
	o e o i h		Others experience others' interactions hypothetically	
4	$\frac{i\ b\ m\ i\ h}{a_2 b_1 c_2 d_2 e_1}$	3	I believe my interactions hypothetically	**Personal hypothetical action
	o e o i p		Others experience others' interactions operationally	Actual group behavior
5	$\frac{i\ e\ m\ i\ h}{a_2 b_2 c_2 d_2 e_1}$	4	I experience my interactions (feelings) hypothetically	**Personal feeling
6	$\frac{i\ e\ m\ i\ p}{a_2 b_2 c_2 d_2 e_2}$	5	I experience my interactions (overt behavior) operationally	**Personal action

[a] No. - number of strong elements: i.e., no. "2" subscripts.

[b] Words in parentheses are part of redundant but consistent statements.

[c] Alternate names in parentheses indicate relationships of various level menbers.

** Combinations used in the ABS-MI/EMO

Figure 1.--Five-Facet Six Level System of Attitude-Behavior Verbalizations: Levels, Facet Profiles, and Definitional Statement for Twelve Combinations.

JOINT STRUCTION

	(A) Referent	(B) Referent Behavior		(C) Actor	(D) Actor's Inter-group Behavior	(E) Domain of Actor's Behavior
(Subject attributes to)	a_1 others a_2 self	b_1 belief (the) b_2 experience	(that the)	c_1 others c_2 self	d_1 compare(s) d_2 interact(s)	e_1 hypothetically e_2 operationally

LATERAL STRUCTION

	(F) Life Situations		(G) Importance		(H) Evaluation Process	
(with the mentally retarded in)	f_1 personal traits f_2 primary group relations f_3 recreation f_4 education f_5 employment f_6 health, welfare and legislation f_7 sex and family f_8 secondary group relations	(involving)	g_1 high g_2 medium g_3 low	(level of importance)	h_1 with respect to h_2 because of h_3 despite	(their)

RESPONSE MODE STRUCTION

(I) Trait Type		(J) Trait Level		(K) Valence		(L) Intensity	
i_1 cognitive i_2 affective i_3 physical-behavioral		j_1 attributed handicap j_2 actual disability	(with)	k_1 negative k_2 neutral k_3 positive	(valence and)	l_1 low l_2 medium l_3 high	(intensity)

[a]Adapted from Harrelson (1970).

Figure 2.--A Mapping Sentence[a] of the Joint, Lateral, and Response Mode Struction Facets Used to Structure the Attitude Behavior Scale-Mental Retardation.

Facet D - "comparative" behavior is weaker than "interactive" behavior since it does not imply social contact. A comparison is more passive than interaction.

Facet E - "symbolic" behavior is weaker than "operational" in that it does not imply acting out behavior.

Application of Facet Theory in Related Studies

As stated in the introduction, this study is based on Guttman-Jordan facet theory. But it is also related to several other studies. The extensive research of Jordan at Michigan State University from eleven European nations and African, Asian, Middle-Eastern, and additional countries have provided empirical tests of the theory. Jordan's Attitude-Behavior Scale-Mental Retardation - ABS-MR (1971) was the principal instrument used by several investigators such as Gottlieb (1970), Harrelson (1971), and Morin (1969). One of the most interesting of the ABS scales is the one used for measuring attitudes toward Blacks and Whites (Jordan, 1968; Hammersma, 1969). The scale was also used in studies by Brodwin (1972) and Smith (1973). The present study used the Attitude-Behavior Scale-Mental Illness-ABS-MI (Dadgostar and Jordan, 1974) and is the first quasi-experimental research study using the ABS type instruments.

TABLE 4.--Comparison of Guttman and Jordan Facet Designations.

Designation	Facets				
Jordan	Referent	Referent Behavior	Actor	Actor's Intergroup Behavior	Domain of Actor's Behavior
	a_1 others	b_1 belief	c_1 others	d_1 comparison	e_1 hypothetical
	a_2 self	b_2 experience	c_2 self	d_2 interaction	e_2 operational
	(I)	(overt action)	(mine/my)		
Guttman		Subject's Behavior	Referent	Referent's Intergroup Behavior	
	- - - - -	b_1 belief	c_1 subject's group	d_1 comparative	- - - - -
	- - - - -	b_2 overt action	c_2 subject himself	d_2 interactive	- - - - -

TABLE 5.--Joint Level or Attitude Level, Profile Composition and Labels for Descriptive Names for Six Levels of Attitude-Behavior.

Level	Descriptive Name
1. Social Stereotype	$a_1\ b_1\ c_1\ d_1\ e_1$
2. Societal Norm	$a_1\ b_1\ c_1\ d_2\ e_1$
3. Personal Moral Evaluation	$a_2\ b_1\ c_1\ d_2\ e_1$
4. Personal Action Hypothetical	$a_2\ b_1\ c_2\ d_2\ e_1$
5. Personal Feeling	$a_2\ b_2\ c_2\ d_2\ e_1$
6. Personal Action	$a_2\ b_2\ c_2\ d_2\ e_2$

CHAPTER III

METHODOLOGY, PROCEDURE, INSTRUMENTATION DESIGN AND HYPOTHESES

The design of this research specified the administration of the Attitude Behavior Scale-Mental Illness/Emotional Problems and an accompanying personal questionnaire to a sample of the patients referred to the out-patient clinic of the Community Mental Health Center. The procedures were designed to measure and test some of the relationships stated in the hypotheses of the study. The study was conducted in a quasi-experimental design using pre-test and post-test measures.

Experimental and Non-experimental Research

Researchers and scientists have two main approaches in their methods[1] of investigation. One is experimental research and the other is non-experimental research. Some researchers are of the opinion that most educational and psychological studies should be experimental and some believe that experiments in psychology and education are unreasonable and even absurd. In general, conditions determine whether to use experimental or non-experimental research. If one

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[1] Problems and procedures of research design are treated more extensively than usual as this study is to be replicated in Iran.

wants to manipulate a particular variable one must use experimental research. Of course, there are many important variables that cannot be studied experimentally because they cannot be manipulated due to social/psychological conditions. For example, intelligence, aptitudes, child training, parents' ability for child training, religious values, ethical issues, conscience, honesty, characteristics of teachers, juvenile delinquency, home environment and many other issues are difficult to manipulate unless operationally defined so specifically as to also arouse considerable debate about philosophical issues. However, some of these variables can be manipulated under special conditions even if they are extremely difficult to create. Kerlinger (1964) believes that some variables are manipulated by nature such as methods of teaching, disciplinary methods, school and class environments, and some behaviors. There are some variables which are both manipulated and measurable, such as anxiety and frustration. Finally, the very multiplicity and complexity of variables tell us that it is misleading to focus exclusively upon either experimental or non-experimental research in psychological, educational, or sociological studies.

Experimental Design

Kirk (1958) has defined experimental design in terms of five correlated activities which any scientific investigation and research hypothesis has to have in order to be reliable and valid. These activities are specified as follows:

1. Formulate statistical hypotheses and make plans for the collection and analysis of data to test the hypotheses. A statistical hypothesis is a statement about one or more parameters of a population. Statistical hypotheses are rarely identical to research or scientific hypotheses but are testable formulation of research hypotheses.
2. State decision rules to be followed in testing the statistical hypotheses.
3. Collect data according to plan.
4. Analyze data according to plan.
5. Make decisions concerning the statistical hypotheses based on decision rules and inductive inferences concerning the probable truth or falsity of the research hypothesis.

Kirk (1968) refers to experimental design in a more restricted and limited sense to describe a particular plan to assign subjects to an experimental condition and the statistical and mathematical analysis which accompany that plan.

Criteria for Evaluation and Experimental Design

Regarding the criteria for evaluation of an experimental design different investigators have presented different ideas. Winer (1962), Lindquist (1953), and Kirk (1968) have presented criteria for evaluating an experimental design:

1. Does the design permit an experimentor to calculate a valid estimate of the experimental effects and error effects?
2. Does the data-collection procedures produce reliable results? Does the design provide maximum efficiency within the constraints imposed by the experimental situation?
3. Does the design possess sufficient power to permit an adequate test of the statistical hypotheses?
4. Does the experimental procedure conform to accepted practices and procedures used in the research area? Other things being equal, an experimentor should use procedures that offer an opportunity for comparison of his findings with the results of other investigations.

The last item is very much suitable in the present study since the same study is to be replicated in other cultures, particularly because the methodology used for the study is so adaptable to cross-cultural studies. The Guttman-Jordan methodology has been used in more than 20 nations. Therefore the power and practicality of the instrument has been shown.

Another main criterion in research design can be examined by asking two questions. (a) Does the design answer the research questions? (b) Does the design adequately test the hypotheses? One further question which must be considered is the question of control. Does the design allow for an adequate control of independent variables?

The investigator must control independent variables so that extraneous and unwanted sources of systematic variances have minimal opportunity to operate (Kerlinger, 1964).

Many investigators have recommended different ways to solve the problems related to confounding and independent variables. Kerlinger (1964) has recommended the following procedures in order to control unwanted variables.

Randomization

1. Randomize whenever possible,
2. Select subjects at random,
3. Assign subject to group at random,
4. Assign experimental treatments to group at random.

Randomization plays an important role in research design. The investigator should attempt to randomize his subjects. While it may not be possible to select subjects at random, it may be possible to assign them to groups at random which can assist in equalizing the subjects to some degree. If random assignment of subjects is not possible, then every effort should be made to administer the experimental treatment to the experimental design, or experimental group. The present research attempted to secure subjects at random and to also randomize the subjects for the type of treatment which they received.

Quasi-Experimental Design

Quasi-experimental design is described by Campbell (1957), and Campbell and Stanley (1953, 1966) and seems to offer a middle ground

between the controlled experiment of the laboratory and the uncontrolled "experiment" of nature. As Campbell and Stanley pointed out, "there are many natural social settings in which the research person can introduce something like experimental design into his scheduling of data collection procedures (e.g., the when and to whom of measurement) even though he lacks full control over the scheduling of experimental stimuli (the when and to whom of exposure and the ability to randomize exposures) which makes a true experiment possible." Collectively, such situations can be regarded as quasi-experimental designs. One purpose of Campbell and Stanley (1966) is to encourage the utilization of such quasi-experiments and to increase awareness of the kinds of settings in which opportunities to employ them occur. But, since full experimental control is lacking, it becomes imperative that the researcher be thoroughly aware of which specific variables his particular design fails to control.

Generalization, Explanation, and Prediction

The type of research design employed can be shown in three ways: generalization, explanation, and prediction.

Generalization: Generalization usually makes a distinction between what is called applied science and what is called basic or pure science. In applied science, the investigator tries to solve some problem or make a decision as a consequence of the results of his study under a special situation. The basic scientist attempts to arrive at a general principle or general law. The most important feature about generalization from a specific sample is that the sample must be

representative of the population. Only when the sample is representative of the population can one generalize from the sample to the population.

In some cases generalization must be restricted to some particular division such as males, females, or to a certain geographical or social situation. In general, one cannot generalize the results to a population unless the values or characteristics of that population interact with the independent variable (McGuigan, 1960).

According to Campbell and Stanley (1966) one cannot make generalizations in logic, since we cannot logically generalize at all.

> Logically we cannot generalize beyond some limits, i.e., we cannot generalize at all. But, we do attempt generalization by guessing at laws and checking out some of these generalizations in other equally specific but different conditions. In the course of the history of science we learn about the "justification" of generalizing by the cumulation of our experience in generalizing, but this is not a logical generalization deducible from the details of the original experiment. Faced by this, we do, in generalizing, make guesses as to yet unproven laws, including some not even explored. Thus, for research on teaching, we are quite willing to assume that orientation in the magnetic field has no effect. But, we know from scattered research that pretesting has often had an effect, and therefore we would like to remove it as a limit to our generalization (Campbell and Stanley, 1966, p. 17).

Prediction and Explanation: Other procedures in scientific investigation are the processes of making predictions and offering explanations. Prediction and explanation are essentially the same thing; the real difference being that one is before and the other after the experiment, respectively. Namely, a prediction is made before the phenomenon is studied, whereas explanation occurs after the phenomenon is observed. In explanation one starts with the

phenomena and logically deduces a general law and the attendant conditions. With prediction, on the other hand, one starts with the general law and antecedent conditions and finally derives the logical consequences.

Pre-test vs. Post-test

The present study employs the Guttman-Jordan methodology of attitude scale construction and analysis. The major purpose of this study was to ascertain the effect of psychotherapy on the attitudes of individuals. Therefore, the Attitude-Behavior Scale-Mental Illness/ Emotional Problems was administered in both a pre-test and post-test situation.

The specific design used in the present study was the "one-group pre-test post-test design." The essential characteristic of this design is that a group is compared with itself. There is no control group since all possible independent variables associated with the subjects' characteristics have been controlled. The procedure calls for a group to be measured on the dependent variable y before any experimental manipulation.

The present study is based on the Kerlinger (1964) formula of Y_1 X Y_2, with Y_1 (group or individual in pre-test) before receiving any treatment and Y_2 (group or individual in post-test) after receiving treatment X, which in the above example is to find out if, due to a special treatment, there is an attitude change toward mental illness. In other words X is the treatment that caused the differences. Campbell and Stanley (1966) have reported that there are a number of

uncontrolled rival hypotheses which effect a study. Finally, after the introduction of this $\underline{X}$ the attitude of subjects is again measured. The difference score, or $\underline{Y}_1$-$\underline{Y}_2$, is examined for any change in opinion or behavior on the part of the subjects. This design seems to be a good way to conduct experimental research. Then if the difference scores are statistically significant, the question remains if it actually signifies a change in attitude? For example, if there is a change in attitude, one may desire to say this change is due to the affect of treatment, but there are a number of other factors, which Campbell and Stanley (1956) call rival hypotheses, which may contribute to the change in scores.

One of these uncontrolled factors is the possible effect of the measurement procedure itself. It is possible that $\underline{X}$ (treatment) measures were influenced not by the manipulation of $\underline{X}$, but by increased sensitization due to the pre-test. This effect may be different for each experimental situation.

The source of difficulty is usually in the pre-test. A pre-test can have a sensitizing effect on the subjects of the study. For example, the subjects may be alerted to some of the events happening in their community or environment that they might not ordinarily notice. If the pre-test is an attitude scale (as the pre-test in this study), it may sensitize the subjects to the issues or problems mentioned in the scale. Then when treatment is administered to the experimental group, the subjects may respond to their own sensitivity to the issue, or to the experimental manipulation, or to both issues. Namely, they have increased their sensitivity and respond accordingly

to the experimental manipulation. Finally, what is called by Campbell and Stanley (1966) "reactive measures" may effect the design.

Another important confounding variable is "history." Events will happen between $\underline{Y}_1$ (pre-test) and $\underline{Y}_2$ (post-test) in addition to treatment $\underline{X}$. Namely, between the $\underline{Y}_1$ and the $\underline{Y}_2$ testings many things can occur to each subject other than the treatment $\underline{X}$. In the present study the affect of history is extremely important because the period between pre-test $\underline{Y}_1$ and post-test $\underline{Y}_2$ was from two months to six months. Therefore, the affect of time and events (history) is extremely important and it was impossible to control these events. In short, if the time lapse between pre-test $\underline{Y}_1$ and post-test $\underline{Y}_2$ is long enough then other factors and extraneous variables may affect the post-test, but conversely, if the time lapse is short, then the post-test $\underline{Y}_2$ is affected by the pre-test $\underline{Y}_1$ itself. The longer the period of time, the greater the chance of extraneous variables affecting the subjects.

There are other variables and events affecting the design which are called maturation variables. Maturation is concerned with the growth (both emotional and physical) of the subjects in the study. This concept includes all psychological, biological, and social processes which are affected by the passing of time, i.e., specific and independent, internal events. Again, as with the concept of history, in maturation the longer the time interval the greater the possibility that extraneous variables will influence the independent variables being measured.

Attitude Behavior Scale and Facet Theory

The methodology for the present study, as a method of evaluation and measurement of attitude of mental patients toward mental illness, is based on an instrument entitled the Attitude-Behavior Scale-Mental Illness/Emotional Problems. This study is based on facet theory and scaling methods developed by Guttman of the Israel Institute of Applied Social Research and the extensive research of Jordan at Michigan State University (1971a, 1971b, 1972). Jordan has developed, expanded, and refined Guttman's attitude facet theory by extending the three-facet, four-level, to a five-facet, six-level design while maintaining the original simplex structure. This method measures a continuum of human behavior from cognitive to overt action. The attitude-behavior scale is a self-report instrument attempting to measure an individual's cognitive, affective, and behavioral aspects of life. There are two main definitions of "attitude" in the literature. One definition denotes "predisposition" to behavior and the second denotes attitude as "behavior," although Jordan (1971) states that attitudes and behavior cannot be separated from each other. Guttman believes that facet theory can be more effective than factor analysis, particularly for qualitative data.

In developing the attitude-behavior instruments, Jordan (1971) made modifications and changes in Guttman's approach by including theoretical and behavioral explanations of human behavior.

The concept and structural organization of attitude research were developed by these modifications through many research projects

done by Jordan and his associates. Utilizing various Attitude-Behavior Scales, it has been possible to analyze the structure and related elements of attitude; consequently producing a more comprehensive and rigorous methodology for attitude research. The Attitude-Behavior Scales have been applied to numerous areas of the social sciences. The six levels of the Attitude-Behavior Scale-Mental Illness are as follows:

1. Societal Stereotype,
2. Societal Norm (Normative),
3. Personal Moral Evaluation,
4. Personal Hypothetical Behavior,
5. Personal Feelings, and
6. Personal Action.

Each level has one more strong element than the immediately preceeding level number and one less strong element than the immediately following level. No element becomes weak once it has been changed from weak to strong (see Table 5, Chapter II). The six levels of the Attitude-Behavior Scale used by Jordan (1967, 1968, 1970, 1971) in the original scale were later used by other investigators in the field of attitude research (Bray and Jordan, 1973; Jordan, 1970; Poulos, 1970; Matthews, 1975; Gottlieb, 1973; Whitman, 1970; Down, 1974; Smith, 1973, 1975; Brodwin, 1973, 1974). The Attitude-Behavior Scale-Mental Illness/Emotional Problems was developed to measure attitudes of selected groups of people who had never been to any type of psychotherapy and had never received any counseling or psychological service. The major concept of the study was to study how a person with emotional

problems views mental illness before he receives psychotherapy and after receiving counseling or psychotherapy. The scale measures the attitude of patients toward mental illness in the following scale areas:

1. marriage to a person with emotional problems;
2. intelligence;
3. understanding of a person with emotional problems;
4. inviting a person with emotional problems;
5. being or becoming the friend of a person with emotional problems;
6. eating with a person who has emotional problems;
7. interacting with a person with emotional problems;
8. accepting a person who has an emotional problem; and
9. lending to people with emotional problems.

These nine areas are the areas that people in general, as well as people with emotional problems, are concerned with in their behavior toward mental illness or toward people with emotional problems.

Giovannoni and Ullman (1963), Maierle (1969), and Whitman (1969) have included some of these areas in their research, which deals mostly with attitudes toward mentally ill or mental illness. The way the questions of the questionnaire were asked present three alternatives for the person answering: (a) disagree with the statement or question, (b) uncertain about it, or (c) agree with the statement or question. Each question was scored such that the higher an individual scores within a level of the scale the more favorable or positive was his attitude toward mental illness or emotional problems.

Rationale

In everyday life we need to know the following about our surrounding environment: (a) what people think others think, (b) what they think is the usual thing that society does, (c) what is the right thing for society to do, (d) what they, themselves, think they would do, and (e) what they actually have done in a situation. These are the six types of attitudes measured by the ABS-MI/EMO (Jordan, 1971).

The Guttman-Jordan scale is an instrument that can be used to measure and analyze attitudes toward any kind of specific object or concept in any specific situation. Three such levels were selected for the purposes of the present study of the attitudes of people with emotional problems, toward mental illness or emotional problems. The three levels selected were: (a) Normative Behavior, (b) Personal Moral Evaluation, and (c) Personal Feeling.

Normative Behavior - Interaction with persons who have emotional problems. The subjects were asked to indicate:

"What, would you say, others think about interaction with persons who have emotional problems?"

Example: Most people believe that others like themselves get married to persons who have emotional problems.

1. disagree
2. uncertain
3. agree

Personal Moral Evaluation - What is believed by others to be right or wrong, in respect to people with emotional problems.

Example: People believe others should be willing to understand persons who have emotional problems.

1. disagree
2. uncertain
3. agree

Personal Feeling - How the subject, himself, feels toward persons who have emotional problems.

Subjects were asked if they "felt" comfortable, uncomfortable, friendly, at ease, around persons who have emotional problems.

Example: I feel comfortable relating intellectually with persons who have emotional problems.

1. disagree
2. uncertain
3. agree

These three levels of attitude-behavior were chosen because it was felt they were the most prevalent ones for the present study and the six level scale was too long for patients in a mental health center.

The Community Mental Health Center of Ingham Medical Hospital (Center) where this study was done is located in the county of Ingham in Lansing, Michigan. The Ingham Medical Hospital (Medical Center) is adjacent to the Community Mental Health Center providing access for hospitalization of patients with serious mental illness or chronic emotional problems (e.g., severe depression, suicidal, drug overdose, etc.). Five programs are offered at the Community Mental Health Center: (a) out-patient, (b) emergency services, (c) in-patient, (d) pre-care and post or after-care, and (e) an activity center. The out-patient program is for people who feel they have some emotional problems or problems of adjustment or relating to others, and need individual or group psychotherapy and counseling. Patients are referred by family, family physicians, medical specialists (neurologists, neurosurgeons, orthopedists, pediatricians, and psychiatrists), friends, school authorities, ministers, probate court, or come in on their own.

Procedures of Administration

The Attitude-Behavior Scale-Mental Illness/Emotional Problems was administered to 29 patients in a pre-test and post-test design. The research process started after the patients made their first contact with the out-patient program of Community Mental Health Center. They were then randomly assigned to a therapist who may be a counselor, psychiatrist, psychologist, or a social workers. Before the initial interview with the therapist, the Attitude-Behavior Scale-Mental Illness/Emotional Problems was given to the patient to fill out (with the patient's consent) for the pre-test. The next stage was to send the patient to therapy. The patient was seen by a therapist, usually once a week, in either individual or group therapy. The duration of therapy varied from one and one half to six months, or from five sessions to 15-20 sessions.

During the initial interview (or after the second or third session) the therapist and patient agreed on the goals of therapy and intervention methods for the future of their contact. The mode of therapy was up to the therapist which was considered a random or uncontrolled variable in the study. Various treatment methods and techniques are used by therapists. While the first contact at the Community Mental Health Center typically involves individual therapy, patients are frequently presented with the alternative of group therapy. The techniques of psychotherapy vary according to the therapist-patient relationship. Consequently all therapeutic techniques were used with no control in the study, such as analytic (Freudian, Jungian, Adlerian), Rogerian (client-centered), behavioral, Gestalt, transitional analysis,

eclecticism, and drug therapy. During the therapeutic relationship if psychotropic, anti-depressant or tranquilizers were needed, the therapist, if not licensed to prescribe medication, describes the behavior and mental status of the patient to the Center's psychiatrist who in turn saw the patient and dispensed appropriate medication. If hospitalization became a serious alternative the therapist was very much involved in this decision and continued to have a therapeutic involvement with the patient. The therapist also has a voice in the discharge plan.

The scales were given to clinets or individuals with emotional problems, with several stages carefully observed during each test administration. The individuals were insured that their responses were confidential, since there was no name on the tests nor any other means of identifying the patient. There was a person or therapist present with each patient in case he or she needed assistance in reading or in understanding a question. Since the subjects were people, ethical issues were a main concern. Before the patient received the questionnaire he was given a consent form to sign regarding his or her cooperation with the research. There was no pressure on the patient to cooperate. A few of these patients had to be hospitalized for medical care. Their median age was 26 years, with a range of 20 to 60 years. The educational level of the group ranged from eight years to 16 years of school with the median being 10.2 years of schooling completed.

Population and Sample

The sample for this study was selected randomly from the population of patients who came to the out-patient service of the Community Mental Health Center of Ingham Medical Hospital, Lansing, Michigan. The sample was selected from that part of the population which had never been to any mental health center, mental institution, counseling center, psychiatric hospitals, or private clinic for psychotherapy. Namely they had never been exposed to any type of psychotherapy. Therefore, psychological and emotional treatment was something new to them. Through the process of selecting the 29 patients who had never had any type of psychotherapy before, the investigator found that only one out of every 35 patients had never experienced therapy before. Problems arose which caused the investigator to postpone the study. Almost 100 patients were selected from this out-patient service of the Community Mental Health Center, but only 29 fully cooperated. Some did not participate at all, some did not show up after the initial interview or after a second or third session, and therefore had to be dropped from the study. Therefore, it took about nine months to secure the 29 subjects: 15 females and 14 males.

Instrumentation

The attitudes of the patients toward mental illness or emotional problems were measured by the Attitude-Behavior Scale-Mental Illness/Emotional Problems in a quasi-experimental situation using a pre-test and post-test scale. The Attitude Behavior Scale is a self report instrument.

The Personal Information Questionnaire

Personal demographic information about each subject in the study was included in the information questionnaire. This information included: (a) sex, (b) age, (c) amount of formal education, (d) marital status, (e) religion, (f) observance of religious rules, (g) other information about their life style, and (h) amount of personal contact with people that have had emotional problems.

Hypotheses of the Study

The variables employed in this study were intercorrelated to enable examination of the relationships between the criterion (ABS-MI) variable(s) across each of the three attitude levels with selected independent variables in a pre and post-test situation. The research hypotheses, which related attitudes to variables such as sex, age, education, and religion, were derived from previous research (Jordan, 1968). The demographic factors were also used by Whitman (1970) in his study of attitudes of psychiatric patients and normals toward the mentally ill.

The hypotheses[1] of the present study deal with attitudes in a quasi-experimental situation using pre and post-test scales.

Hypothesis 1: If psychotherapy affects attitudes toward emotional problems or mental illness, then a person who receives psychotherapy will experience a change in his attitudes towards mental illness or emotional problems, or in other words, persons who score low on the pre-test will be high on the post-test.

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[1]The hypotheses are stated in the research form although in the statistical analyses the null form is followed.

There have been some studies regarding this hypothesis. Some reported a change in attitudes toward mental or emotional illness. Gunther and Brilliant (1964) investigated changes in attitudes toward mental illness with regard to the effects of psychotherapy. Foa (1968) conducted a quasi-experimental research and reported changes in attitudes and behaviors of the subjects. Gunther, Reznikoff, and Fisherman (1963) conducted a comparative study (attitude of parents toward treatment, psychiatrists, and hospitals). They did not report directly about the affects of treatment (therapy) on changing attitudes.

Instrumentation: The instrumentation which was used to test Hypothesis I was the Attitude-Behavior Scale-Mental Illness/Emotional Problems.

Analysis: The analysis of data was obtained through correlation between the three levels of the ABS-MI(EMO) and "t" tests between pre-test and post-test scores.

Hypothesis II: Age will be negatively related to positive attitudes toward mental or emotional illness.

There have been some studies regarding age and attitudes toward mental illness. One of the best studies was done by Kastenbaum and Durkee (1964). They reported on the affect of age on attitudes toward mental or emotional illness. Kastenbaum and Durkee's study was supported by other investigators such as Merrill and Gunter (1969).

Instrumentation: The instrument used to test Hypothesis II was the Attitude Behavior Scale-Mental Illness/Emotional Problems.

Analysis: The analysis of data was obtained by correlations between age and attitude level of the ABS-MI(EMO) in the pre-test and post-test situations.

Hypothesis III: Amount of education will be positively related to attitudes toward emotional problems or mental illness. Namely, amount of education will be related to favorable attitudes toward mental and emotional illness.

Clark and Binkston (1966) reported on the relationship of age and education to attitudes toward mental and emotional illness.

Instrumentation: The instrument used to test Hypothesis III was the Attitude Behavior Scale-Mental Illness/Emotional Problems.

Analysis: The analysis of data was obtained by correlations between amount of education and attitudes in order to ascertain relationships between attitudes toward mental illness or emotional problems.

Level of Significance

The three hypotheses were accepted or rejected at the .05 level of significance. This level of significance was chosen to further safeguard against certain uncontrolled factors in the experiment such as history, small sample size, and lack of a control group.

CHAPTER IV

RESULTS

This chapter deals with the analysis of the data. For the convenience of the reader, the means and standard deviations for each variable for both the pre-tests and the post-tests are shown in Tables 6-10. The correlations for each variable between the pre and post-tests and their significance levels are also given in Tables 6-10.

The three hypotheses of the present study were analyzed by the procedures indicated in Chapter III.

Hypothesis I

The first hypothesis states that psychotherapy affects attitudes toward emotional problems or mental illness, and therefore after receiving psychotherapy for a period of time, a person will experience a change in his/her attitudes toward mental illness or emotional problems.

Rationale: There have been few studies conducted on the effects of psychotherapy on attitudes toward mental illness. Gynther and Brilliant (1964) did a study regarding the effects of psychotherapy on attitudes. Foa (1968) reports some changes in attitudes

TABLE 6.--Sample Sizes, Means and Standard Deviations for the Variables[a] of the ABS-EMO[b] Study.

Variable[c]	Score Range	Pre-Test (28)			Post-Test (28)			r and P of Pre and Post-Test		t[e]
		N	Mean	SD	N	Mean	SD	r	P	
1. Norm	8-24	28	16.36	3.91	28	16.31	5.20	.49	.005	.05
2. Moral	8-24	28	18.96	4.06	28	19.18	4.53	.52	.002	.27
3. Feel	8-24	28	19.32	3.57	28	19.61	3.83	.51	.004	.42
4. Sex	1-2	28	1.50	.51	28	1.50	.51	*		
5. Age	1-5	28	2.11	1.29	28	2.14	1.27	*		
6. Education-amt.	1-5	28	3.68	.86	28	3.75	.80	.95	<.00005	
7. Marital status	1-5	28	2.50	2.29	28	2.50	1.29	*		
8. Religion	1-5	28	3.18	1.06	28	3.00	.98	*		
9. Relig.-importance	1-5	28	3.39	.88	27	3.22	1.56	.74	<.00005	3.49
10. Relig.-rules	1-5	28	3.07	1.25	27	2.96	1.32	.42	.02	.37
11. Set ways	1-5	28	2.21	1.23	28	2.54	1.23	.68	<.00005	1.78
12. Action-respons.	1-5	28	4.71	.54	28	4.82	.48	.66	.0001	1.39
13. Recrea. Involv.	1-5	28	4.25	1.14	28	4.36	.91	.55	.001	.59
14. Emo. contact	1-5	28	2.43	1.43	28	2.50	1.43	.63	.0002	.3
15. Emo. contact-joy	1-5	28	2.93	.86	28	3.18	.67	.02	.90	6.02
16. Emo. contact-avoid	1-5	27	3.89	1.45	28	3.82	1.44	.24	.19	2.09
Simplex Analysis[d]		OQ^2_2 = .99 BQ^2 = .99			OQ^2_2 = .88 BQ^2 = .99					

[a]Based on the 11-22-73 edition of the ABS-EMO.
[b]ABS-EMO = Attitude-Behavior Scale: Emotional Problems.
[c]See text for meaning of variables.
[d]Simplex Analysis via the Kaiser Q^2 technique: OQ^2 = "original" (empirical)
BQ^2 = "best" possible with data
[e]For $t \geq 2.05$, with df = 26, $P \leq .05$.
*Categorical variables.

TABLE 7.--Sample Sizes, Means and Standard Deviations for the Female Group on the Variables[a] of the ABS-EMO[b] Study.

Variable[c]	Score Range	Pre-Test (14)			Post-Test (14)			r and P of Pre and Post-Test	
		N	Mean	SD	N	Mean	SD	r	P
1. Norm	8-24	14	17.36	3.88	14	16.62	5.61	.26	.32
2. Moral	8-24	14	19.50	4.17	14	19.71	4.29	.33	.20
3. Feel	8-24	14	20.14	2.98	14	20.00	3.35	.72	.001
4. Sex	1-2	14	1.00	.00	14	1.00	.00	*	
5. Age	1-5	14	2.14	1.41	14	2.14	1.41	*	
6. Education-amt.	1-5	14	3.50	.86	14	3.64	.76	.90	<.00005
7. Marital status	1-5	14	2.93	1.14	14	2.57	1.09	*	
8. Religion	1-5	14	3.57	.94	14	3.29	.73	*	
9. Relig.-importance	1-5	14	3.57	.65	14	3.43	1.09	.71	.001
10. Relig.-rules	1-5	14	3.07	1.00	14	2.50	1.23	.47	.06
11. Set ways	1-5	14	2.50	1.16	14	2.64	1.22	.51	.03
12. Action-respons.	1-5	14	4.86	.36	14	4.93	.27	.67	.003
13. Recrea. involv.	1-5	14	4.21	1.12	14	4.21	1.12	.63	.008
14. Emo. contact	1-5	14	2.93	1.64	14	3.07	1.49	.72	.001
15. Emo. contact-joy	1-5	14	3.21	.71	14	3.14	.66	.92	<.00005
16. Emo. contact-avoid	1-5	14	4.14	1.46	14	3.71	1.82	.19	.47
Simplex Analysis[d]		OQ^2 = .99 BQ^2 = .99			OQ^2 =.59 BQ^2 =.92				

[a]Based on the 11-22-73 edition of the ABS-EMO.
[b]ABS-EMO = Attitude-Behavior Scale: Emotional Problems.
[c]See text for meaning of variables.
[d]Simplex analysis via the Kaiser Q^2 technique: OQ^2 = "original" (empirical)
BQ^2 = "best" possible with data.

*Categorical variables.

TABLE 8.--Sample Sizes, Means and Standard Deviations for the Male Group on the Variables[a] of the ABS-EMO[b] Study.

Variable[c]	Score Range	Pre-Test (14)			Post-Test (14)			r and P of Pre and Post-Test	
		N	Mean	SD	N	Mean	SD	r	P
1. Norm	8-24	14	15.36	3.82	14	16.00	4.95	.77	.00005
2. Moral	8-24	14	18.43	4.03	14	18.64	4.86	.68	.003
3. Feel	8-24	14	18.50	4.01	14	19.21	4.35	.37	.15
4. Sex	1-2	14	2.00	.00	14	2.00	.00	*	
5. Age	1-5	14	2.07	1.21	14	2.14	1.17	*	
6. Education-amt.	1-5	14	3.86	.86	14	3.86	.86	.10	<.00005
7. Marital status	1-5	14	2.07	1.33	14	2.00	1.24	*	
8. Religion	1-5	14	2.79	1.05	14	2.71	1.14	*	
9. Relig.-importance	1-5	14	3.21	1.05	13	3.00	1.23	.76	.0009
10. Relig.-rules	1-5	14	3.07	1.49	14	3.46	1.27	.43	.10
11. Set ways	1-5	14	1.93	1.27	14	2.42	1.28	.82	.0001
12. Action-respons.	1-5	14	4.57	.65	14	4.71	.61	.63	.007
13. Recrea. Involv.	1-5	14	4.29	1.20	14	4.50	.65	.49	.05
14. Emo. contact	1-5	14	1.93	1.00	14	1.93	1.14	.26	.32
15. Emo. contact-joy	1-5	14	2.64	.93	14	3.21	.70	.58	.01
16. Emo. contact-avoid	1-5	13	3.62	1.45	14	3.93	1.00	.46	.08
Simplex Analysis[d]		OQ^2 = .99 BQ^2 = .99			OQ^2 = .99 BQ^2 = .99				

[a]Based on the 11-22-73 edition of the ABS-EMO.
[b]ABS-EMO = Attitude-Behavior Scale: Emotional Problems.
[c]See text for meaning of variables.
[d]Simplex Analysis via the Kaiser Q^2 technique: OQ^2 = "Original" (empirical)
BQ^2 = "best" possible with data

*Categorical variables.

TABLE 9.--Sample Sizes, Means and Standard Deviations for the Age Group 20-24 on the Variables[a] of the ABS-EMO[b] Study.

Variable[c]	Score Range	Pre-Test (12)			Post-Test (12)			r and P of Pre and Post-Test	
		N	Mean	SD	N	Mean	SD	r	P
1. Norm	8-24	12	16.67	4.33	12	15.64	4.51	.49	.07
2. Moral	8-24	12	19.17	3.51	12	18.33	4.68	.24	.39
3. Feel	8-24	12	19.25	3.25	12	18.83	4.55	.32	.26
4. Sex	1-2	12	1.42	.52	12	1.42	.52	*	
5. Age	1-5	12	1.00	.00	12	1.00	.00	*	
6. Education-amt.	1-5	12	3.67	.99	12	3.83	.84	.92	<.00005
7. Marital status	1-5	12	2.08	1.08	12	1.83	.94	*	
8. Religion	1-5	12	2.83	.84	12	2.83	.84	*	
9. Relig.-importance	1-5	12	3.42	.79	12	2.91	1.31	.82	.0003
10. Relig.-rules	1-5	12	2.67	1.30	12	2.92	1.31	.51	.059
11. Set ways	1-5	12	2.25	1.29	12	2.83	1.12	.66	.009
12. Action-respons.	1-5	12	4.67	.49	12	5.00	.00	.00	1.00
13. Recrea. Involv.	1-5	12	4.17	1.27	12	4.50	1.17	.67	.008
14. Emo. contact	1-5	12	2.20	1.38	12	2.67	1.37	.57	.031
15. Emo. contact-joy	1-5	12	2.92	.90	12	3.17	.58	.14	.61
16. Emo. contact-avoid	1-5	12	4.27	1.27	12	4.08	1.31	.91	<.00005
Simplex Analysis[d]		OQ^2 = .99 BQ^2 = .99			OQ^2 = .98 BQ^2 = .98				

[a]Based on the 11-22-73 edition of the ABS-EMO.
[b]ABS-EMO = Attitude-Behavior Scale: Emotional Problems.
[c]See text for meaning of variables.
[d]Simplex Analysis via the Kaiser Q^2 technique: OQ^2 = "original" (empirical)
BQ^2 = "best" possible with data.

*Categorical variables.

TABLE 10.--Sample Sizes, Means and Standard Deviations for the Age Group 25 and Over on the Variables[a] of the ABS-EMO[b] Study.

Variable[c]	Score Range	Pre-Test (16)			Post-Test (16)			r and P of Pre and Post-Test	
		N	Mean	SD	N	Mean	SD	r	P
1. Norm	8-24	16	16.13	3.69	16	16.81	5.75	.53	.022
2. Moral	8-24	16	18.81	4.54	16	19.81	4.46	.72	.0006
3. Feel	8-24	16	19.38	3.90	16	20.19	3.23	.71	.0009
4. Sex	1-2	16	1.56	.51	16	1.56	.51	*	
5. Age	1-5	16	2.94	1.12	16	3.00	1.03	*	
6. Education-amt.	1-5	16	3.69	.79	16	3.69	.79	1.00	.00005
7. Marital status	1-5	16	2.81	1.38	16	2.63	1.26	*	
8. Religion	1-5	16	3.44	1.15	16	3.13	1.09	*	
9. Relig.-importance	1-5	16	3.38	.96	15	3.47	.99	.78	.0002
10. Relig.-rules	1-5	16	3.38	1.15	15	3.00	1.36	.37	.14
11. Set ways	1-5	16	2.19	1.22	16	2.31	1.30	.71	.0009
12. Action-respons.	1-5	16	4.75	.58	16	4.69	.60	.91	.00005
13. Recrea. involv.	1-5	16	4.31	1.08	16	4.25	.68	.42	.07
14. Emo. contact	1-5	16	2.38	1.50	16	2.38	1.50	.67	.002
15. Emo. contact-joy	1-5	16	2.94	.85	16	3.19	.75	.12	.62
16. Emo. contact-avoid	1-5	16	3.63	1.54	16	3.63	1.54	-.11	.63
Simplex Analysis[d]		OQ^2 = .97 BQ^2 = .97			OQ^2 = .94 BQ^2 = .95				

[a]Based on the 11-22-73 3dition of the ABS-EMO.
[b]ABS-EMO = Attitude-Behavior Scale: Emotional Problems.
[c]See text for meaning of variables.
[d]Simplex Analysis via the Kaiser Q^2 technique: OQ^2 = "original" (empirical)
BQ^2 = "best" possible with data.

*Categorical variables.

of people after receiving psychotherapy. There are other studies which report findings that do not support Hypothesis I, such as those by Gynther, Reznikoff and Fisherman (1963). Their comparative study (dealing with attitudes of patients toward treatment, psychiatrists, and hospitals) showed that attitudes toward psychiatrists, treatment procedures, and mental hospitals are indirectly related to positive attitudes toward mental illness or emotional problems.

Instrumentation: The instrumentation used to test Hypothesis I was the ABS-MI (EMO).

Analysis: The analysis of data was obtained through correlations between three levels ofthe ABS and "t" tests between pre and post-test scores.

Results: The data indicate that the pre-test group scored high on level 1 (Normative), while the post-test group scored higher on level 2 (Moral) and on level 3 (Feeling).

The t-tests indicated no significance between pre-test and post-test scores in the three attitude levels. Therefore the hypothesis was not supported.

Hypothesis II

There have been studies regarding the relationships between age and attitudes toward mental illness. Hypothesis II states that age will be negatively related to attitudes toward mental illness.

Rationale: The most comprehensive study was done by Kastenbaum and Durkee (1964). They reported that age affects attitudes toward mental or emotional problems. Kastenbaum and Durkee's study was supported by another study by Merrill and Gunter (1969).

Instrumentation: The instruments used to measure Hypothesis II was the ABS-MI (EMO) and the subjects reported age.

Analysis: The analysis of data was obtained by correlations between age and attitude levels of the ABS-MI/EMO in the pre and post-test situations.

Results: Hypothesis II was not supported at either of the three attitude levels (Normative, Moral Evaluation, and Feeling) in either the pre-tests or the post-test situation. The correlations between the pre-test attitude levels and age range from -.05 to .12, which are not statistically significant, and the correlations between the post-test attitude levels and age range from -.06 to .15. None of these correlations are statistically significant. Therefore it can be stated that Hypothesis II is not supported by the research data.

Hypothesis III

Hypothesis III states that amount of education will be positively related to attitudes toward mental illness.

Rationale: Many studies have been conducted regarding relationships between education, and particularly amount of education, and attitudes toward mental illness. One of the most detailed studies was done by Clark and Binksont (1966). They reported on the relationships between age and attitudes and educational levels and attitudes toward emotional problems. Their study was supported by other investigators such as Whitman (1970).

Instrumentation: The instrument used to measure Hypothesis III was the ABS-MI (EMO) and the subjects reported amount of education.

Analysis: Correlations between amount of education and attitudes were obtained in order to ascertain relationships between attitudes toward mental illness or emotional problems and amount of education.

Results: The hypothesis was not supported at any of the three attitude levels in either the pre-test and the post-test. Correlation between pre-test attitude levels and amount of education ranged from .11 to -.26, none of which are statistically significant. The correlations between the post-test attitude levels and amount of education ranged from -.02 to .28; again these correlations were not significant at any level (Tables 6-10).

For additional correlations and statistical information the reader is referred to Table 7, which contains correlations between all of the variables in both the pre and post-test situations for female subjects, and to Table 8 for the male subjects.

Summary and Implications

The data of the study show that "recreational involvement" correlated significantly with level 2 (Moral evaluation); i.e., recreational involvement may be a good predictor of positive attitudes toward mental illness in a post-test situation. It is also shown to be a good predictor at level 3 in the post-test situation. Recreational involvement is also positively correlated with the Moral Evaluation attitude level for the pre or post test.

"Emotional contact-enjoy," variable 15, was also significantly related to positive attitudes toward mental illness for the pre-test

data. In other words, if a person has enjoyed being with an emotionally disturbed person before he received psychotherapy, he will also tend to feel more enjoyment being with that person after receiving psychotherapy. In conclusion, emotional contact-enjoy in the pre and post-test situation is positively correlated with attitude level 3 (Feeling) in the post-test.

The "emotional contact-avoid" variable correlated negatively with attitude level 1 (Normative) on the post-test. In other words, people with emotional problems who have been avoided emotionally by others, will tend to not interact with other people who also have emotional problems.

The variable "set in own ways" in the pre-test situation is shown by the data to be a good predictor of Moral Evaluation attitudes (level 2) in the post-test.

The data indicate no change in age in the pre-test and post-test situation, but a slight change in amount of education was noted. This change was due to the time lapse between the pre-test situation and the post-test situation (i.e., some of the subjects were in psychotherapy for more than six months and therefore may have also received additional training or educational experience during this time). Small changes were also observed in the variable "marital status" since some of the subjects had changed their status between pre and post-test times; i.e., some of the subjects had reported marital problems on entering psychotherapy, or had been separated at the time of the pre-test, and after receiving psychotherapy they decided to alter their previous status.

Limitations of the Study

The present study, like any experimental and quasi-experimental study, was affected by certain confounding and uncontrolled variables.

1. History. The time between the pre-test and the post-test was enough to affect social, family, educational, and other factors influencing the persons' scores on the post-test.

2. Lack of a Control Group. As it was stated in Chapter III, it was not possible to have a control group for the study due to the aspect of "with-holding" treatment from those indicating need of such.

3. Sample Size. A specific limitation of the study was the small sample size. It was extremely difficult to find clients who had never been to any type of psychotherapy.

4. Other Factors. There were other limitations such as varied techniques of psychotherapy and client-therapist relationship skills which were uncontrolled factors in the experiment.

CHAPTER V

SUMMARY, DISCUSSION, IMPLICATIONS, AND RECOMMENDATIONS

The first four chapters of the study dealt with the introduction, review of literature, the methodological aspects of the study, and the analysis of data. In this chapter, attempts are made to present a summary of the study, within the described limitations, and to present a series of recommendations, both general and specific.

Summary

Attitudes related to mental illness or emotional problems have been considered primarily in terms of how the lay public, parents, and professional people (both mental health workers and non-mental health personnel), view the mentally ill, and mental illness or emotional problems. Very little systematic or organized attention has been paid to the views and attitudes of mental patients or people with emotional problems toward each other or toward mental illness. Also little systematic attention has been given to the views and attitudes of those patients and the impact they might have on one another in a type of experimental or semi-experimental situation.

The major purpose of the present study was to test the effects of psychotherapy on attitudes in a quasi-experiemental research, using pre-test and post-test techniques. A related aim of this study was to create a scale of Attitude-Behaviors toward Mental Illness or Emotional Problems (ABS-MI/EMO) based on the Guttman-Jordan facet theory methodology.

This type of research is projected to produce a more complete understanding and conceptualization of the area of mental illness and thus help to motivate the development of educational and training programs for those who work in the field of mental health. People, in general, are unaware of the fact that attitudinal levels are important with regard to the amount of contact a person has had with another person with emotional problems, with regard to the value orientation of that person, and with regard to certain specified demographic characteristics. Attitudes of people with emotional problems, in an experiemntal or comparative basis, are far from clear and are in great need of research in order to delineate their structural determinants, and their content.

Briefly the purposes of the present study were the following:

1. To measure attitudes of people with emotional problems who have never been exposed to any type of psychotherapy, in a quasi-experimental situation before and after treatment.
2. To construct an Attitude-Behavior Scale-Mental Illness or Emotional Problems (ABS-MI/EMO), according to the methodology and formulation of Guttman (1957, 1959, 1966),

Jordan (1968, 1971) and Whitman (1970) using people with emotional problems as subjects.

3. To determine the predictive ability of a series of hypothesized determinants, such as demographic characteristics, educational level, and value orientations.
4. To test the facet theory contiguity hypotheses with regard to attitude scale construction.

The procedures permitted the testing of these research hypotheses which relate attitudes toward mental illness or emotional problems to the variables previously mentioned. These variables were selected from those used in previous studies done by Jordan (1968) and Whitman (1970).

The three research hypotheses tested in the present study were:

Hypothesis I: Psychotherapy will be positively related to attitudes toward mental or emotional problems.

Hypothesis II: Age will be inversely related to positive attitudes toward mental illness or emotional problems.

Hypothesis III: Amount of education will be positively related to attitudes toward mental illness or emotional problems.

The first hypothesis was not supported since the statistical *t* test indicated lack of significance between pre and post attitudes. The second and third hypotheses were not supported at any of the attitude levels in either the pre-test or the post-test, but significant changes did occur on other variables. For example, both "emotional contact-

enjoy" and "emotional contact-avoid" were related to positive attitudes toward mental illness, and there was a significant correlation between "emotional-contact-enjoy" and level 2 (Moral Evaluation) of the attitude levels.

Discussion

The present study indicated no change in attitude toward mental illness or emotional problems after the subjects received treatment or therapy. Possibly, there are other factors which affected the subjects between the time of the pre-test and the post-test (for a discussion of these factors the reader is referred to Chapter III). Or possibly, in order to overcome an emotional problem or solve some mental difficulty it is not necessary to change one's attitude toward mental illness or emotional problems.

There were other difficulties in the research design which made the study difficult to conduct. There are many situations in which people with emotional problems are able to handle their problems without seeking professional counseling or therapy (i.e., religious influences, friends, or self). Another difficulty of this study was the absence of a control group. It was impossible to find a group of people with no emotional problems who would participate in the study.

Failure to find significant differences between pre-test and post-test subjects, both females and males, and between age groups may be due to a lack of cooperation on the part of the subjects. Out of the 100 patients who had never received therapy, 45 agreed to participate in the pre-test but only 29 of these responded to the post-test. There are several reasons why some of the subjects were unwilling

to participate in the study. Some of the patients were afraid of any kind of test, while others were uneasy about participating due to fears about the confidentiality of the information they were required to give on the scales. They felt threatened by the scales and felt their life and/or their values would be jeopardized by participating in the study.

Replication of this study will be the basis of a cross-cultural study in Iran. The present study laid the foundation for future comparative studies. If the results, at the cross-cultural level, are not significant, then new research can be developed which will assist in determining the following: (a) whether attitudes toward mental illness or emotional problems change due to therapeutic treatments, (b) if there are changes in attitudes, and if these changes are positive or negative, and (c) what type of therapeutic approach was used when the change occurred.

This research suggests that therapy may not change the cognitive attitudes of people, although it may effectively modify some of their overt behavior. While adjustment may be heightened through therapy, attitudes toward mental or emotional problems may remain the same.

Implications

Mental health practitioners, researchers, and those who work in related areas have constantly offered their ideas and suggestions regarding the importance of mental health in the community. The Joint Commission on Mental Illness and Mental Health, in a publication by the National Institute of Mental Health (pp. 262-263) made several

suggestions which contain instructions for the mental health field. Those which they considered to be the most important are the following: (a) To provide treatment through basic mental health teams for persons with acute mental illness; (b) To care for those who have not recovered completely, either through admission to a hospital or mental institute or through follow-up services after discharge from a hospital or mental institute; (c) To provide a headquarters for mental health consultants working with mental health workers or counselors.

There have been other recommendations which have come from professionals in the mental health field and from other investigators which include the following: (a) effective participation by the communities served, (b) development of a comprehensive information base for program description, (c) evaluation and research undertaken by selected community mental health centers, (d) support for that research by either the regional, state or federal government, (e) close cooperation between universities and research institutes for human services, and the community mental health centers, in the areas of consultation research and training, and (f) contact with other agencies regarding the prevention of mental illness or emotional problems, i.e., providing consultation education in order to prevent possible problems and disturbances which jeopardize the emotional life of a person.

Areas Needing Further Investigation

As a result of this investigation, it has become increasingly apparent that the following unsubstantiated statements describe important areas related to research in the field of mental health in which further research is much needed at the present time.

1. Therapists and mental health workers in general must be careful in attempts to change attitudes of patients toward their problems.
2. Older people need more care in order to help them solve their emotional problems.
3. The five programs of Community Mental Health Centers are: (a) out-patient, (b) emergency services, (c) pre-care and aftercare, (d) in-patient, and (e) consultation and education. More attention should be paid to consultation and education which is mainly concerned with prevention.
4. The mental health worker should be more involved with the community. The therapist should go into the community. and deal with the family whenever possible.
5. Extend local residential placement center as a liaison between mental institutions and the community.

APPENDIX A

CONSENT FORM

Ingham Medical Hospital
Community Mental Health Center
401 W. Greenlawn
Lansing, Michigan 48910

PATIENT CONSENT FORM

Our center is in the process of a research project regarding the patients who use the services of the center. Therefore, we would like you to fill out a questionnaire. It will take about 10 - 15 minutes of your time before the initial interview and 10 - 15 minutes after a few sessions of psychotherapy.

We would greatly appreciate your participation in this project. Please sign the form below indicating your choice. If you are uncertain, please feel free to discuss your concern with your therapist. Thank you very much for your cooperation.

Check one please:

1. I am willing to participate in this research project. _____

2. I am not willing to participate in this research project. _____

DATE: _____

SIGNATURE: _____

BD/ran

APPENDIX B

ATTITUDE BEHAVIOR SCALE -

ABS-EMO

ATTITUDE BEHAVIOR SCALE - ABS-EMO

DIRECTIONS

This booklet contains statements of how people behave in certain situations or feel about certain things. You, yourself, or other persons often behave in the same way toward everyone, including persons who have emotional problems.

By persons who have emotional problems we mean those children or adults whose behaviors, feelings, or emotions cause them to have difficulties with everyday problems which they are unable to solve without help.

You also have some general ideas about yourself, about other persons like you, and about persons who have an emotional problem. Sometimes you feel or behave the same way toward everyone and sometimes you feel or behave differently toward persons who have emotional problems. Here is a sample question:

Sample 1

1. Other people believe they are more attractive than most persons who have emtional problems.

   (1) agree
   2. uncertain
   3. disagree

   If others believe that persons who have emotional problems have less chance than they have to be attractive, you should circle the number 1 as shown above.

********** DO NOT PUT YOUR NAME ON THE BOOKLET **********

by: John E. Jordan
Bahman Dadgostar
College of Education
Michigan State University

ABS-1.2-EMO

Directions: Section 1.2

This section contains statements about interacting with persons who have emotional problems. Please choose the answer that indicates what you think others believe about interacting with persons who have emotional problems.

Most people believe the following about interacting with persons who have emotional problems:

1. Most people believe that others like themselves get married to persons who have emotional problems.

   1. disagree
   2. uncertain
   3. agree

2. Most people believe that others like themselves like to intellectually interact with persons who have emotional problems.

   1. disagree
   2. uncertain
   3. agree

3. Most people believe that others like themselves relate understandingly to persons who have emotional problems.

   1. disagree
   2. uncertain
   3. agree

4. Most people believe that others like themselves invite persons who have emotional problems into their homes.

   1. disagree
   2. uncertain
   3. agree

5. Most people believe that others like themselves have friends who are persons who have emotional problems.

   1. disagree
   2. uncertain
   3. agree

ABS-1.2-EMO

Most people believe the following about interacting with persons who have emotional problems:

6. Most people believe that others like themselves eat with persons who have emotional problems.

   1. disagree
   2. uncertain
   3. agree

7. Most people believe that others like themselves accept help from persons who have emotional problems.

   1. disagree
   2. uncertain
   3. agree

8. Most people believe that others like themselves lend things to persons who have emotional problems.

   1. disagree
   2. uncertain
   3. agree

ABS-2.3-EMO

Directions: Section 2.3

This section contains statements of the right or wrong way of behaving or acting toward persons with emotional problems. You are asked to indicate what you believe others think should be done with respect to such persons.

In respect to persons with emotional problems, what do you believe others think is right or wrong:

9.1 People believe others should be willing to marry persons who have emotional problems.

1. disagree
2. uncertain
3. agree

10.2 People believe others should be willing to intellectually enjoy being with persons who have emotional problems.

1. disagree
2. uncertain
3. agree

11.3 People believe others should be willing to understand persons who have emotional problems.

1. disagree
2. uncertain
3. agree

12.4 People believe others should be willing to invite persons who have emotional problems into their homes.

1. disagree
2. uncertain
3. agree

13.5 People believe others should be willing to be friends with persons who have emotional problems.

1. disagree
2. uncertain
3. agree

ABS-2.3-EMO

In respect to persons with emotional problems, what do you believe others think is right or wrong:

14.6 People believe others should be willing to eat with persons who have emotional problems.

1. disagree
2. uncertain
3. agree

15.7 People believe others should be willing to accept help from persons who have emotional problems.

1. disagree
2. uncertain
3. agree

16.8 People believe others should be willing to lend things to persons who have emotional problems.

1. disagree
2. uncertain
3. agree

ABS-3.5-EMO

Directions: Section 3.5

This section concerns feelings that anyone might have about persons who have emotional problems. You are asked to indicate how you yourself feel about the following statements.

How do you yourself feel toward persons who have emotional problems.

17.1 I feel comfortable about marrying a person with emotional problems.

1. disagree
2. uncertain
3. agree

18.2 I feel comfortable relating intellectually with persons who have emotional problems.

1. disagree
2. uncertain
3. agree

19.3 I am able to be understanding with persons who have emotional problems.

1. disagree
2. uncertain
3. agree

20.4 I feel comfortable about inviting persons to my home who have emotional problems.

1. disagree
2. uncertain
3. agree

21.5 I feel friendly toward persons who have emotional problems.

1. disagree
2. uncertain
3. agree

22.6 I feel at ease about eating with persons who have emotional problems.

1. disagree
2. uncertain
3. agree

ABS-3.5-EMO

How do you yourself feel toward persons who have emotional problems.

23.7 I feel all right about accepting help from persons with emotional problems.

1. disagree
2. uncertain
3. agree

24.8 I feel comfortable about lending things to persons who have emotional problems.

1. disagree
2. uncertain
3. agree

ABS-EMO-D

This part of the booklet deals with many things. Part of the questionnaire has to do with information about you. Since the questionnaire is completely anonymous or confidential, you may answer all of the questions freely without any concern about being identified. It is important to obtain your answer to every question.

Read each question carefully and do not omit any questions. Please answer by circling the answer you choose.

25. Please indicate your sex.

    1. Female
    2. Male

26. Please indicate your age as follows:

    1. 20-25 years
    2. 26-30 years
    3. 31-40 years
    4. 41-50 years
    5. 51 years or over

27. About how much education do you have?

    1. 6 years of school or less
    2. Between 7 and 9 years of school
    3. Between 10 and 12 years of school
    4. Some college or training after high school
    5. A college or university degree

ABS-EMO-D

28. What is your marital status?

    1. Married
    2. Single
    3. Divorced
    4. Separated
    5. Widowed

29. What is your religion?

    1. I prefer not to answer
    2. Catholic
    3. Protestant
    4. Jewish
    5. Other or none

30. About how important is your religion to you in your daily life?

    1. Not at all important
    2. Not very important
    3. Neither important nor unimportant
    4. Fairly important
    5. Very important

31. In respect to your religion, to what extent do you observe the rules and regulations of your religion?

    1. Almost never
    2. Rarely
    3. Occasionally
    4. Frequently
    5. Almost always

ABS-EMO-D

32. Some people are more set in their ways than others. How would you rate yourself?

1. I find it very difficult to change
2. I find it slightly difficult to change
3. I find it neither difficult nor easy to change
4. I find it somewhat easy to change
5. I find it very easy to change

33. I feel responsible for my actions as follows: (Circle one answer only).

1. Almost never
2. Rarely
3. Occasionally
4. Frequently
5. Almost always

34. I like to be involved in some kind of work, recreational, or hobby activities as follows: (Circle one answer only).

1. Almost never
2. Rarely
3. Occasionally
4. Frequently
5. Almost always

This part of the questionnaire deals with your experiences or contacts with persons who have had emotional problems. Perhaps you have had much contact with persons who have emotional problems or perhaps you may never have had any contact or experience with them.

ABS-EMO-D

35. Have you had any experiences with persons who have emotional problems. Considering all of the times you have talked. worked, or in some other way had personal contact with such persons, about how many times has it been altogether?

1. Less than 10 occasions
2. Between 10 and 50 occasions
3. Between 51 and 100 occasions
4. Between 101 and 500 occasions
5. More than 500 occasions

36. How have you generally felt about your experiences or contacts with persons who have emotional problems.

1. I definitely disliked it
2. I did not like it very much
3. I neither liked it nor disliked it
4. I liked it somewhat
5. I definitely enjoyed it

37. In your contact or experiences with persons who had emotional problems, what opportunities did you have to associate with someone else such as friends or relatives that are acceptable to you. In other words, did you solitarily choose the contact.

1. No one else is available
2. Other people available are not at all acceptable to me
3. Other people available are not quite acceptable to me
4. Other people available are slightly acceptable to me
5. Other people available are fully acceptable to me

ABS-EMO-D

38. My therapy has consisted mostly of the following: (Circle each one that you have had).

1. I have not had any therapy before.
2. Medications
3. Assignment to activities such as Occupational Therapy (O.T.), Corrective Therapy (C.T.), etc.
4. Group therapy
5. Individual therapy

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