Attitudes of Occupational Therapy Students toward the Mentally Disabled

McCarthy

Follow this and additional works at: https://scholarworks.wmich.edu/masters_theses

Part of the Health and Physical Education Commons, and the Occupational Therapy Commons

Recommended Citation
https://scholarworks.wmich.edu/masters_theses/829
ATTITUDES OF OCCUPATIONAL THERAPY STUDENTS TOWARD THE MENTALLY DISABLED

by

Patricia McCarthy

A Thesis
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Master of Science
Department of Occupational Therapy

Western Michigan University
Kalamazoo, Michigan
August 1993
ATTITUDES OF OCCUPATIONAL THERAPY STUDENTS TOWARD THE MENTALLY DISABLED

Patricia McCarthy, M.S.
Western Michigan University, 1993

Thirty-nine undergraduate occupational therapy and fifty-seven entry-level graduate occupational therapy students from eight randomly selected academic programs were surveyed using the Opinions About Mental Illness Scales ([OMI], Cohen and Struening, 1959) and the Mental Health Information Questionnaire ([MHIQ], Nunnally, 1961). Results revealed that both student groups' knowledge toward the mentally disabled was more similar to the general public's knowledge. Using a one-tailed t-test to compare the MHIQ factors revealed there was no statistically significant difference between the occupational therapy student groups.

Both student groups' OMI factor scores were similar to an expert group for Factors A, B, and D; however, both student groups endorsed Factors C and E. A one-tailed t-test compared the OMI factors between student groups revealing graduate students endorsed Factor D ($t = 2.67, p < .5$). There were no statistically significant differences for Factors A, B, C, and E.
ACKNOWLEDGMENTS

For the guidance and support I have received in the preparation and completion of this thesis, there are numerous people I wish to extend my thanks and appreciation too. First, my committee members, Richard Cooper, Joan Uhley, and Shirley Lukens, are deserving of the utmost respect and appreciation for their patience, effort, and assistance during the timely completion of this thesis.

Second, to Jane Lyon, who has continued to be a guardian angel during my academic pursuits in occupational therapy.

Lastly, to my entire family, for their endless support and encouragement, I am deeply indebted. Their unfailing belief in my abilities was, and continues to be, a constant motivating source.

Patricia McCarthy
INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.
Attitudes of occupational therapy students toward the mentally disabled

McCarthy, Patricia Ann, M.S.
Western Michigan University, 1993
# TABLE OF CONTENTS

ACKNOWLEDGEMENTS................................................................. ii

LIST OF TABLES........................................................................ v

CHAPTER

I. INTRODUCTION........................................................................ 1

   Rationale.................................................................................. 2

   Purpose..................................................................................... 3

   Questions.................................................................................. 3

II. REVIEW OF RELATED LITERATURE...................................... 5

   Development of Attitudes Toward
   Persons With Disabilities......................................................... 5

   Children's Attitudes................................................................. 6

   Attitudes of Health Professionals........................................... 7

   Attitudes Toward the Mentally Disabled............................... 8

   Measurement of Attitudes....................................................... 11

   Summary.................................................................................. 11

   Hypotheses............................................................................. 12

   Definitions............................................................................... 13

III. METHODOLOGY................................................................. 14

   Population............................................................................... 14

   Instruments............................................................................. 14

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
Table of Contents--Continued

CHAPTER

Mental Health Information Questionnaire .............................. 15
Opinions About Mental Illness Scales ..................................... 17
Procedure ....................................................................................... 18
Data Analysis ................................................................................... 19
Opinions About Mental Illness Scales ..................................... 19
Mental Health Information Questionnaire .............................. 20
Results .............................................................................................. 20
Subjects ...................................................................................... 20
Opinions About Mental Illness Scales ........................ 21
Mental Health Information Questionnaire .............................. 23

IV. DISCUSSION ........................................................................................ 26

Limitations ..................................................................................... 30
Conclusions ...................................................................................... 30

APPENDICES

A. Mental Health Information Questionnaire ............................................ 32
B. Opinions About Mental Illness Scales ................................................... 38
C. Introduction Letter .................................................................................. 47
D. Cover Letter ............................................................................................ 49
E. Human Subjects Institutional Review
   Board Letter of Approval ....................................................................... 51

BIBLIOGRAPHY ............................................................................................. 53

iv
LIST OF TABLES

1. Mean Sten Scores for Present Sample, Expert, and Public Groups on the Five OMI Factors .................................................. 22

2. Mean Scores on Ten Factors for the Mental Health Information Questionnaire for Nunnally's Sample and Present Sample ........................................................................ 24
CHAPTER I

INTRODUCTION

The roles of the occupational therapist in treatment of the mentally disabled changed dramatically over the past decade. The community health movement and the trend toward deinstitutionalization restructured the general philosophy and services provided to the mentally disabled individual (Kielhofner & Barris, 1984). As practitioner roles changed, there was a concurrent role change for the mentally disabled consumer of occupational therapy services. Mentally disabled persons were often considered a mysterious subset within the population as opposed to contributing members of society. Rabkin (1974) noted that "the recipients of such services, and those who deal with them, exist in the larger context of society" (p. 9). As professionals, occupational therapists focused on the mentally disabled persons' functional outcomes within the community. Occupational therapists also analyzed activities so that environmental factors and performance components were considered when choosing and/or adapting the appropriate activity for this population. These services provided by occupational therapists to the mentally disabled consumer were essential for independent functioning. Thus, the need to assess the attitudes of therapists toward the mentally disabled was a necessary requirement to identify a possible barrier to the number of occupational therapists working within the domain of mental health.
Rationale

As of 1990, there were 38,900 certified occupational therapists in the United States (AOTA, 1991). The demand and need for occupational therapists has been well documented with the vocational market for occupational therapists increasing by 50% by the 21st century (Silvestri & Lukasiewicz, 1989). According to projections of the United States Bureau of Labor and Statistics, occupational therapy will rank 16th among all professions in growth through the year 2000 (Silvestri & Lukasiewicz, 1989) with the total number of employed registered occupational therapists' exceeding 45,000 (Silvestri & Lukasiewicz, 1989). The major areas of occupational therapy practice in 1990 were school systems, 18.6%; rehabilitation hospitals and/or centers, 11.4%; rehabilitation units of general hospitals, 5.3%; all other general hospitals, 15.9%; pediatrics, 1.7%; psychiatric hospitals, 4.6%; private practice, 7.7%, and all other, 34.8% (AOTA, 1991). Of the occupational therapy practitioners, 41.8% considered themselves to be generalists while the remaining 58.2% considered themselves to be specialists (AOTA, 1991).

The fact that over 50% of therapists considered themselves 'specialists' rather than 'generalists' has greatly affected practice. Gibson (1984) reported that "fewer occupational therapists [were] employed in long- or short-term psychiatric hospitals, and more [were] employed in public schools, home health agencies, and in private practice" (p. 135). Statistics supported this observation. In 1973, 13.8% of registered occupational therapists were employed in a psychiatric hospital as
opposed to the 4.6% documented in 1990 (AOTA, 1991).

With the projected shortage of occupational therapists in all areas of practice, persons with mental health problems will receive fewer services if this downward trend continues. Numerous studies hypothesized that attitudes affected the way in which individuals behaved toward certain populations. Previous studies have investigated occupational therapy student attitudes toward the physically disabled and geriatric populations (Mills, 1972; Benham, 1988; Lyons, 1991); however, no studies were found which documented attitudes toward the mentally disabled. Since students comprise a large percentage of potential mental health practitioners, the need to investigate student attitudes toward the mentally disabled is appropriate.

Purpose

The purpose of this study was to investigate the attitudes of occupational therapy students toward the mentally disabled.

Questions

This investigation of attitudes of occupational therapy students toward the mentally disabled sought more information on the following research questions:

1. What are the attitudes of undergraduate students in occupational therapy toward the mentally disabled?

2. What are the attitudes of graduate students in occupational therapy
toward the mentally disabled?

3. Is there a difference between the attitudes of undergraduate and graduate occupational therapy students toward the mentally disabled?

4. Is there a difference between the attitudes of occupational therapy students and the general public toward the mentally disabled?

5. Is there a difference between the attitudes of occupational therapy students and experts in mental disabilities toward the mentally disabled?
CHAPTER II

REVIEW OF RELATED LITERATURE

Development of Attitudes Toward Persons With Disabilities

Every human being has distinct feelings toward the world in which one resides. These feelings may be positive or negative, may be directed towards an object, and can be defined as attitudes (Kiel, 1990, p. 279).

Development of attitudes received much attention from researchers. However, a large portion of previous research was not theoretical (Kiel, 1990). Yet, theories of human development play a significant part in directing research (Kiel, 1990). Altman (1981) noted that the general public's negative reaction to individuals with various disabilities and/or handicaps was well documented; yet, the body of knowledge addressing the cause of negative reactions and attitude development was not a substantially supported area.

Bender (1980) cited Beatrice Wright and Harold Yuker as viewing "negative attitudes towards disabled persons as being similar to the prejudicial attitudes directed toward minority groups" (p. 427). Analysis of these attitudes can be traced to one's socialization process, childhood fears, reaction of the 'non-disabled' to negative behavior of disabled individuals, as well as one's historical cultural values (Bender, 1980).
Rousch (1986) furthered this point stating that attitudes were learned. People acquired attitudes from others’ actions and reactions to various situations and individuals. These reactions developed from negative media images rather than from perceived characteristics of the disabled individual. Rousch (1986) also noted the use of language as a facilitator of negative stereotypes toward the disabled. Words such as crippled, quad, retarded, crazy, and lunatic affected one’s behavior toward and perception of the disabled person. Literary works were another area where disabled individuals were negatively portrayed. Captain Hook in Peter Pan, Quasimodo in The Hunch Back of Notre Dame, and Eve from the Three Faces of Eve were all examples of literary characters with disabilities who were presented as evil and/or villainous (Rousch, 1986).

Children's Attitudes

In a review of the literature of children’s attitudes toward persons with disabilities, Morrison and Ursprung (1987) stated that researchers consistently documented that negative attitudes toward the physically disabled developed during childhood. Zimbardo and Ebbesen (1970) also stated that the groups to which one belonged strongly influenced one’s behavior. Behavior was rewarded if one conformed to the standards and attitudes of a group. Deviation from these standards and attitudes resulted in punishment. These attitudes persisted into adulthood; however, Ryan (1981) stated that as children aged, children understood their feelings and beliefs better. Therefore, children became more aware.
of others' subjective perspectives.

Weiss (1985) also found that children's attitudes changed in a positive direction as their grade/age increased. Weiss stated that attitudes tended to stabilize between Grades 6 and 8 and theorized that these attitudes were most likely similar to adults attitudes at this age/grade.

Attitudes of Health Professionals

As individuals grew and matured, personal histories were acquired (Burnett-Beaulieu, 1982). In the case of health care workers, these histories were brought into the therapeutic environment (Burnett-Beaulieu, 1982). Therapeutic relationships were greatly affected by the health care workers' history and subsequent attitudinal beliefs (Estes, Deyer, Hansen, & Russell, 1991). These attitudes must be examined because nondisabled persons' attitudes toward disabled individuals will help us to better understand the interaction between the two (Yuker, 1965).

More importantly, health care workers provided primary support and rehabilitation services for the disabled individual. As potential advocates, the health care workers' attitudes were extremely important in terms of the disabled person's opportunities and potential roles adopted within the larger context of society (Benham, 1988).

Investigating occupational therapy personnel attitudes toward disabled persons, Benham (1988) found highly favorable attitudes existed within this population. Westbrook and Adamson (1989) found positive attitudes were demonstrated
toward the disabled by occupational therapy students, with senior students possessing more positive attitudes than first year students. They also found that students' knowledge was inadequate concerning the lives of handicapped people. Lyons (1991) did not find a significant difference in attitudes between occupational therapy students and business students toward the physically disabled; however, an increase in positive attitudes toward the physically disabled was revealed of people who had more social role contact with this population.

Another study investigating rehabilitation employers' and general employers' attitudes toward hiring handicapped persons found that these two groups demonstrated similar attitudes which were moderately positive (Colorez & Geist, 1987). These authors felt that comparing this finding to previous research suggested that more favorable attitudes existed among the general and rehabilitation employers toward the disabled (Colorez & Geist, 1987).

Attitudes Toward the Mentally Disabled

Chubon (1982) summarized that negative attitudes towards disabilities were often suggested as one barrier toward the attainment of a personally fulfilling life for the disabled person. Rabkin (1977), specifically focused on the mentally disabled and stated that the general public viewed mental illness as unfavorable. A review of the current literature did not support this generalization concerning negative attitudes. The literature did reveal the existence of a range of attitudes toward the mentally disabled which spanned from negative to positive (Olmstead
Johnson (1984) found that a more favorable disposition toward the mentally ill existed as compared to several decades ago and that the public was better informed about mental illness. D'Arcy and Brockman (1977) reported a trend toward more tolerant attitudes toward the mentally disabled; however, they also noted a large variance in the amount of change that was noted. This review revealed a lack of consistency among research findings. Segal (1978), in a review of attitudes toward the mentally disabled presented the concept that mental illness currently existed within a broad category. Attitudes in regard to mental disability as a broad category tended to be positive; however, the public continued to manifest negative attitudes toward a smaller group that was considered seriously mentally disabled.

In a study assessing the attitudes of nursing students and others about mental illness, Morrison, Yablonovitz, Harris and Nevid (1976) found that student nurses possessed moderate attitudes about the mentally ill; they did not possess the radical beliefs about the mentally disabled (e.g., mental illness was a myth) that more psychology students held. Compared to teacher-students in education, student nurses were less conservative (e.g., mental illness was a disease); however, student nurses' attitudes were similar to those of psychiatric nurses.

In a survey concentrating on stigma associated with mental illness, Wahl and Harmony (1989) concluded that families of mentally disabled persons felt they were subjected to stigmatizing and expected it. Thus, while it was found that the
mentally ill person was the actual object of the public's negative attitude, the family also felt stigmatized.

In a semantic differential study assessing the stability of mental health attitudes, Olmstead and Durham (1976) found that the attitudes of the college student in 1962 compared to a comparable population of college students in 1971 were similar. Thus, no significant change had occurred in a positive direction toward the mentally disabled. However, Miller, Lenkowski, and Weinstein (1979) found that medical students' positive attitudes increased regarding mental health ideology and interpersonal etiology following a two-month psychiatric clerkship. These authors also found that the increase in the mental hygiene ideology was sustained over a period of time.

Keane (1991) surveyed medical students using the Opinions about Mental Illness questionnaire. This study found that attitudes positively increased on Benevolence and Personal Etiology after an eight week clinical and academic course in psychiatry. Lieberman (1970) compared college students to the general public and found the students to be better informed about the mentally disabled. Also, the students who were less authoritarian (e.g., perceiving the mentally ill person as threatening and inferior thus requiring coercive handling) were better informed about mental illness.

Although the literature currently addressed attitudes towards the physically disabled as commonly measured by the Attitudes Toward Disabled Persons Scale (Yuker, Block, & Young, 1966), attitudes toward the mentally disabled were not
as heavily documented within the profession of occupational therapy.

Measurement of Attitudes

Attitudes toward the mentally disabled has been measured by various scales and questionnaires. Gilbert and Sullivan (cited in Antonak & Livneh, 1988) constructed the Custodial Mental Illness Ideology Scale. This scale determined whether respondents' attitudes were custodial (traditional medical model belief of a highly controlled setting), or humanistic (individuality and humans needs emphasized as well as the hospital as a therapeutic community), and placed the results on a continuum (Antonak & Livneh, 1988). The Mental Health Information Questionnaire (MHIQ) was constructed by Nunnally (1961) to investigate the public's knowledge and thoughts concerning mental health. Opinions about Mental Illness Scales (OMI) developed by Cohen and Struening (1959) sought to measure attitudes toward mentally disabled persons and their personal characteristics. It also sought to measure attitudes toward mental illness, its etiology and treatment (Antonak & Livneh, 1988). The Client Attitude Questionnaire (CAQ) as developed by Morrison (cited in Antonak & Livneh, 1988) provides a continuum for attitudes ranging from conservative to radical.

Summary

In summary, the literature documented a number of studies concerning the attitudes of various populations toward the physically disabled. The literature
revealed an increasingly positive trend in attitudes toward the physically disabled. Attitudes toward the mentally disabled were not addressed as extensively, but revealed a range of attitudes toward the mentally disabled. Research concerning the attitudes of occupational therapy students toward the mentally disabled was not found.

Hypotheses

The lack of literature regarding the attitudes of occupational therapy students toward the mentally disabled supports the need for such a study. Based on the literature review and previous findings, there is an indication that undergraduate and graduate occupational therapy students will display more positive attitudes toward the mentally disabled than the general public. There is also support for the belief that graduate occupational therapy students will display more positive attitudes toward the mentally disabled than undergraduate students; therefore, directional hypotheses will be used for this study. Thus, this study investigated the hypotheses that:

1. Undergraduate occupational therapy students will display a more positive attitude toward the mentally disabled than the general public.

2. Graduate occupational therapy students will display a more positive attitude toward the mentally disabled than the general public.

3. Undergraduate occupational therapy students will display attitudes similar to the attitudes of experts.
4. Graduate occupational therapy students will display attitudes similar to the attitudes of experts.

5. Graduate occupational therapy students will display more positive attitudes toward the mentally disabled than undergraduate students.
   
   A. A significant difference (p<.05) will be found between the factor means for graduate and undergraduate occupational therapy students on the Mental Health Information Questionnaire.
   
   B. A significant difference (p<.05) will be found between the factor means for graduate and undergraduate occupational therapy students on the Opinions about Mental Illness Scales.

Definitions

An undergraduate student was defined as an individual enrolled in an accredited undergraduate occupational therapy program in the United States during the Spring semester of the year 1992.

A graduate student was defined as an individual enrolled in an accredited graduate occupational therapy program in the United States during the Spring semester of the year 1992.

A mentally disabled person was defined by the World Health Organization (1980) as an individual with "any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being" (p. 7).
CHAPTER III

METHODOLOGY

Population

In 1991, there were 9,667 persons enrolled in professional level occupational therapy programs. Of these 9,667 students, 82.7% were enrolled in baccalaureate programs, 1.5% in post-baccalaureate certificate programs, 2% in programs offering a certificate in partial fulfillment of a master's degree, 2.3% in a combined baccalaureate/master's program, and 11.5% in professional master's programs. Demographic characteristics of these students were as follows: 8.6% male, 91.4% female, 1.4% disabled, 23.7% older than 25 years of age, 89.4% White, 3.8% Black, 3.5% Hispanic, 2.6% Asian, .16% Native Americans, and .48% classified as other (AOTA, 1992).

Instruments

Two questionnaires, the Mental Health Information Questionnaire (MHIQ) (see Appendix A) and Opinions About Mental Illness Scales (OMI) (see Appendix B) were administered.
Mental Health Information Questionnaire

The Mental Health Information Questionnaire (MHIQ) was constructed by Nunnally (1961) to investigate the public's knowledge and thoughts about mental health. This questionnaire consisted of 60 items that were followed by a seven-point Likert scale with a range from completely disagree to completely agree. A higher score on the MHIQ corresponds to a positive agreement with the factor being measured.

Ten information factors were obtained from a factor analysis performed on previous versions of the MHIQ, as well as 20 additional items termed interesting; but, these 20 items were not related to any factor. The factors are as follows:

I. Look and Act Different - the manner and appearance of the mentally disabled are noticeably different from normal persons.

II. Will Power - People do not try hard enough to become better.

III. Sex Distinction - A higher percentage of women are more susceptible to mental illness than men.

IV. Avoidance of Morbid Thoughts - Preservation of mental health is obtained through one's preoccupation with pleasant thoughts.

V. Guidance and Support - By depending upon strong people, a person can maintain his/her mental health.

VI. Hopelessness - Mental disabilities are incurable.

VII. External Causes versus Personality - Pressures from the environment
such as social and financial strains and physical exhaustion cause mental disabilities. Another aspect of this view believes that mental health is dependent upon an individual's personal history.

VIII. Non-seriousness - Mental disabilities are not important and cause little damage to the individual.

IX. Age Function - The older one becomes, the more likely one is to develop a mental disability.

X. Organic Causes - Mental health problems are organic in nature.

The validity of the MHIQ was supported by the differences in scores among various sample groups. Nunnally (1961) compared a group termed as experts to a group termed as laymen. The expert group consisted of a sample of psychiatrists and psychologists. The laymen were individuals randomly selected from the general population. Compared to the experts, Nunnally (1961) found the laymen to be well informed about mental disabilities; however, they were not as knowledgeable as the expert group with respect to all the factors expect Factor X, Organic Causes. The public sample matched the expert group in knowledge for this factor.

Information regarding the reliability of the MHIQ is lacking. There is no information reported by Nunnally (1961) and no other study addressing the reliability has been located (Antonak & Livneh, 1988).
Opinions About Mental Illness Scales

The Opinions About Mental Illness Scales (OMI) were devised by Cohen and Struening (1959). This instrument assessed attitudes toward mental illness, its etiology, and its treatment. The OMI consisted of 51 statements followed by a six-point rating scale to which the responder indicated the amount of agreement. A higher score indicated a stronger endorsement of the factor being measured.

The OMI has undergone extensive factor analysis which organized the statements into five factors as follows:

Factor A. Authoritarianism: Perceives the mental disabled as threatening and inferior and a group that requires coercive handling.

Factor B. Benevolence: A humanistic and moral outlook toward the mentally disabled; a paternalistic orientation to the mentally disabled.

Factor C. Mental Health Ideology: Belief that mental disability can be treated successfully.

Factor D. Social Restrictiveness: The mentally disabled are perceived as a threat to society especially in social functioning.

Factor E. Interpersonal Ideology: Perception of mental disability as a result of interpersonal experiences.

The OMI has been one of the most extensively used instruments to measure
which coupled with the results from numerous studies supports the validity of the OMI (Antonak & Livneh, 1988).

Reliability of the OMI was measured through a series of internal consistency studies. The results for the factors were as follows: +.77 to +.80 for Factor A; +.70 to +.72 for Factor B; +.29 to .39 for Factor C; +.71 to .76 for Factor D; +.65 to +.66 for Factor E (Cohen & Struening, 1963). Other data concerning the reliability of the OMI was not reported (Antonak & Livneh, 1988).

Procedure

Sixty-eight letters requesting assistance with the distribution of the two questionnaires, Opinions about Mental Illness Scales (OMI) and Mental Health Information Questionnaire (MHIQ), were sent to the directors of 15 entry level master's and 53 undergraduate accredited occupational therapy programs (see Appendix C). A self-addressed postcard was enclosed in order for the directors to document their response to the request for assistance, as well as specify a date most convenient for participation.

Of the 68 universities/colleges contacted, 45 responded. Six of these respondents did not agree to participate; eight did not meet the availability requirements for participation and were excluded. Of the remaining 31 universities/colleges, eight were randomly selected to participate.

A total of forty, two part, questionnaires were sent to the directors of the
eight randomly selected occupational therapy programs. Part 1 of the questionnaire asked for demographic information about the participant. Part 2 was the OMI and MHIQ. Each participant was instructed to complete the demographic information and the OMI and MHIQ. The questionnaires were distributed by a faculty member to a maximum of 20 students who voluntarily agreed to participate. A letter accompanied the questionnaires explaining the purpose of the study. This letter also explained that participation was voluntary and that anonymity was a requirement for participation (see Appendix D).

The subjects were asked to answer all questions. After the questionnaires were completed, the students placed them in an envelope. When all the questionnaires were placed in the envelope, a designated faculty member sealed the envelope and mailed them to the principal investigator.

Data Analysis

Opinions About Mental Illness Scales

The data compiled from each individual questionnaire was placed in the appropriate formula as computed by Cohen and Struening (1962). The resulting scores of the occupational therapy students were compared to the general public and a group of psychologists as defined and surveyed by Cohen and Struening (1963). The group termed as the general public were citizens who were visitors to a county fair in Kansas that had stopped at a mental health booth and com-
pleted the Opinions About Mental Illness Scales. The psychologist's group were Veteran Administration chief psychologists. A one-tailed t-test was used to compare the occupational therapy students' factor scores. An alpha of .05 was used to determine if there was a statistically significant difference between the two groups.

Mental Health Information Questionnaire

The individual scores obtained from each questionnaire were placed into the appropriate factor groups as derived by Nunnally (1961). The resulting scores were compared to an expert group which, as defined by Nunnally (1961), were a sample of psychiatrists belonging to the Group for the Advancement of Psychiatry and a sample of psychologists. Scores were also compared to a group termed as laymen by Nunnally (1961) which was defined as the general public. A one-tailed t-test was performed to compare the occupational therapy student groups. An alpha of .05 was used to determine if there was a statistically significant difference between the two groups.

Results

Subjects

A total of 96 graduate and undergraduate students participated in this study. Of these 96 students, 59.4% (57) were enrolled in professional master's programs
and 40.6% (39) were enrolled in baccalaureate programs. Demographic characteristics for this population were as follows: 93.8% female, 6.2% male, 90.6% White, 4.2% Black, 2.1% Hispanic, 3.1% Asian, 78.1% single, 17.7% married, 5.2% divorced, and 39.6% older than 25 years of age. The average age of the participating students was 26.8 years. Comparing the demographic information compiled in this study to the national norms compiled by the American Occupational Therapy Association (1991) does not reveal generalizable results for various demographics addressed. Gender was a factor that was similar between the national norms and the population of this study.

Opinions About Mental Illness Scales

Table 1 presents the mean sten scores of the student groups as well as the psychologists and Kansas citizens as surveyed by Cohen and Struening (1963). With regards to Table 1, it should be remembered that the raw OMI scores were transformed to sten scores (Canfield, 1951) which is a standardized "one digit score with a mean of 4.5 and a standard deviation of 2" (Cohen & Struening, 1963, p. 113). Therefore, if the group means are within one half a sten unit, this will place these scores within one-quarter of a standard deviation, hence statistically insignificant (Cohen & Struening, 1963).

From Table 1, it was seen that undergraduate students were similar to the psychologists in Factors B and D, higher on Factor A, but lower on Factors C and
# Table 1

Mean Sten Scores for Present Sample, Expert and Public Groups on the Five OMI Factors

<table>
<thead>
<tr>
<th>Factors</th>
<th>Mean Sten Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Psychologists</td>
</tr>
<tr>
<td>A. Authoritarianism</td>
<td>2.1</td>
</tr>
<tr>
<td>B. Benevolence</td>
<td>4.1</td>
</tr>
<tr>
<td>C. Mental Hygiene Ideology</td>
<td>6.6</td>
</tr>
<tr>
<td>D. Social Restrictiveness</td>
<td>1.7</td>
</tr>
<tr>
<td>E. Interpersonal Etiology</td>
<td>5.2</td>
</tr>
</tbody>
</table>


E. These results suggest that undergraduate students are more authoritarian; however, undergraduate students are less likely to subscribe to the orientation that mental illness is an illness like any other and the belief that mental illness is a result of interpersonal experiences than the group of psychologists.

Graduate students, when compared to the psychologists’ group are similar in Factors A and B, higher on Factor D and lower on Factors C and E. These
results suggest that graduate students are more socially restrictive; however, graduate students are similar to the undergraduate student in that graduate students are less likely to subscribe to the view that mental illness has an interpersonal etiology and the belief that mental illness is an illness like any other as compared to the group of psychologists.

When compared to the public sample, both the undergraduate and graduate students scored lower on all factors. These results suggest that occupational therapy students are less authoritarian and benevolent toward the mentally disabled. Students are also less likely to believe that mental disability can be treated successfully and the mentally disabled pose a threat to society. Students also do not subscribe to the belief that mental disabilities are a result of interpersonal experiences.

Using a one-tailed t-test to compare the OMI factor scores between undergraduate and graduate students revealed no statistically significant difference at the .05 level for Factors A, B, C, and E. Factor D, social restrictiveness, did reveal a statistically significant difference ($t = 2.67, p < .05$) between the two groups.

**Mental Health Information Questionnaire**

Table 2 lists the mean scores of the MHIQ for the student groups as well as the expert and public groups as surveyed by Nunnally (1961). For Factors I,
<table>
<thead>
<tr>
<th>Factors</th>
<th>Mean Sten Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nunnally Experts</td>
</tr>
<tr>
<td>I. Look and Act Different</td>
<td>2.4</td>
</tr>
<tr>
<td>II. Will Power</td>
<td>2.2</td>
</tr>
<tr>
<td>III. Sex</td>
<td>3.8</td>
</tr>
<tr>
<td>IV. Avoidance of Morbid Thoughts</td>
<td>3.4</td>
</tr>
<tr>
<td>V. Guidance and Support</td>
<td>4.2</td>
</tr>
<tr>
<td>VI. Hopelessness</td>
<td>2.3</td>
</tr>
<tr>
<td>VII. External Causes vs. Personality</td>
<td>3.4</td>
</tr>
<tr>
<td>VIII. Non-seriousness</td>
<td>3.7</td>
</tr>
<tr>
<td>IX. Age Function</td>
<td>2.5</td>
</tr>
<tr>
<td>X. Organic Causes</td>
<td>2.7</td>
</tr>
</tbody>
</table>

II, VI, VII, IX, and X, both the undergraduate and graduate students scored higher as compared to the expert group. For Factors IV and V students scored lower and the students' scores were comparable for Factors III and VIII. These results suggest that students tend to endorse the belief more than the expert sample that the mentally disabled look and act different, do not exert enough will power, are incurable, respond to environmental stimuli, are more likely to be older and have an illness which is caused by organic problems. Results also suggest that students do not believe a mental disability can be avoided by thinking pleasant thoughts, relying on strong people and that it is not a seriousness health problem.

Comparing the general public sample to the occupational therapy students reveals that students scored higher on Factors I, VI, IX, and X; scored lower on Factors III, IV, and V, and were similar for Factors II, VII, and VIII. The comparisons here are similar to the comparison between the expert group except students tended not to endorse the belief that women suffered from mental disabilities more often than men.

Using a one-tailed t-test to compare undergraduate and graduate students' scores did not reveal a statistically significant difference at the .05 level for any of the MHIQ factors.
CHAPTER IV

DISCUSSION

The results of the OMI and MHIQ were not as expected. This author hypothesized that graduate students possessed attitudes that were more positive toward the mentally disabled as compared to undergraduate students. This belief was based on the assumptions that graduate students had more life experiences and a greater educational base which would manifest as more positive attitudes than undergraduate students. This was not the case. The only statistically significant difference found in this study was a stronger tendency by graduate students to perceive the mentally disabled as a threat to society. These findings, as Lyons (1991) suggests, emphasize the need to maintain an appropriate level of skepticism before a certain set of beliefs and/or attitudes can be attributed to occupational therapy students. This may be an important point in terms of screening the potential occupational therapy student.

Findings from the comparison between the OMI scores for the student samples to the psychologist and public samples also were not as expected. This author hypothesized that both student samples would be more similar with the psychologist group than the public group on all factors. However, Factors C (Mental Hygiene Ideology) and E (Interpersonal Etiology) varied greatly when compared to the psychologist group and to a lesser extent the public group.
Hence, students appear to endorse the belief that the mentally disabled cannot be treated successfully and that interpersonal experiences do not play a large part in the development of mental disabilities.

Comparison of the MHIQ between the student, expert, and public samples revealed students tended to agree more with the publics' scores. Again, this finding was not expected as it was hypothesized that students entering an allied health field would be more knowledgeable about the mentally disabled than the average citizen. It would appear then, that another aspect to be addressed when assessing potential health professionals' attitudes is the knowledge one possesses about various disabilities (Westbrook & Adamson, 1989). These findings have great implications within the profession of occupational therapy. The attitudes and knowledge revealed by the OMI and MHIQ responses in this present study could help explain why the number of occupational therapists entering the field of mental health is declining. Potential therapists who do not believe mental disabilities can be treated successfully have other options to choose from which begs the question, "Are students as potential practitioners abandoning the mentally disabled population because of an inaccurate knowledge base and negative attitudes?"

Scott (1990) found that the knowledge bases for physical disabilities and mental health differ which may be attributed to the curriculums' emphasis on theory and techniques within the area of physical disabilities. Kielhofner and Barris (1984) substantiate this belief with a review of psychosocial literature which revealed no dominating orientation, trend, or pattern for occupational therapists
practicing mental health during a 10 year period. Kielhofner and Barris (1984) also found that therapists tended to support more than one perspective but endorsed the paradigm of occupation derived from early occupational therapy.

Previous studies addressed students' thoughts about mental health practice and coursework and found students felt psychosocial occupational therapy was not objective, concrete, specific, structured, and empirical (Christie, Joyce, & Moeller, 1985a; Page, 1987). It would appear then that identification of psychosocial theory, techniques, skills, coursework, and responsibilities required for practice is imperative (Barris & Kielhofner, 1986).

Lack of consistent theory and concepts and non-delineated and undifferentiated roles of the occupational therapist were recurring themes that prevailed in the specialty area of mental health for occupational therapy. If the profession continues to operate without a common knowledge base and passes this inconsistency along in the classroom and treatment facilities, where is the student as a potential practitioner as well as the current practitioner left? Lyons (1991) believes "if students do not possess positive attitudes by the time they graduate, then the profession, through its educators and practitioners must hold itself responsible for enculturation that has failed" (p. 315).

Occupational therapy as a career choice is a factor which required examination. Earlier research revealed students chose occupational therapy because of the direct working relationship with other people and the ability to help disabled persons (Picket, 1962) and this was a consistent finding over the years (Patterson,
Marion, & Patterson, 1970; Holmstrom, 1975; Madigan, 1985). Recent research also found that students chose occupational therapy for altruistic reasons; however, it was also found that this was not the major motivating factor for choosing occupational therapy (Rozier, Gilkeson, & Hamilton, 1992). Students chose occupational therapy over other helping professions because of the increased job availability, salaries, regular hours, and prestige associated with the vocation (Rozier, Gilkeson, & Hamilton, 1992).

Shifting priorities related to entering the profession of occupational therapy, coupled with the findings of this study are important to the domain of mental health within occupational therapy. If students are choosing a career for economic advantages and prestige, the following questions come to mind: Are students' more concerned with having a job as opposed to having a satisfying and likeable job; thus, entering the profession of occupational therapy with negative attitudes in order to meet vocational needs? Are the students' attitudes found in this study a reflection of job seekers first and potential advocates second? Also, if students' knowledge concerning the mentally disabled is lacking, other troubling questions need to be addressed. Questions such as: Are students receiving the appropriate information about and interaction with the mentally disabled population through the educational process? Are the curriculums of occupational therapy programs neglecting the domain of mental health? Are the hopes and expectations of the faculty influencing the students' perceptions of the mentally disabled? Is the screening process for entry level occupational therapy students
adequate? These points are extremely important because as potential health care workers, occupational therapy students’ attitudes can influence and affect client-therapist relationships (Altman, 1981), as well as the outcome of the therapeutic process (Bruhn, 1984).

Limitations

Limitations of this study have been identified. First, the return rate of the instrument was 35% which was not considered an acceptable response rate for survey research (Babbie, 1973). Second, only eight occupational therapy programs were randomly selected and used in this study. Third, the validity and reliability of the MHIQ was questionable; however, the OMI is an often used instrument. Fourth, the faculties’ perceptions and attitudes as well as the content of the occupational therapy programs curriculums’ content were not examined. Finally, attitudes of undergraduate and graduate students were examined. There are other variables such as number of years enrolled in an occupational therapy program, age, sex, contact with a mentally disabled individual, and specialty area students seek to enter which need to be researched.

Conclusions

The results of this study indicate that occupational therapy students were not as well informed about the mentally disabled when compared to an expert group as measured by the MHIQ. The students’ attitudes as measured by the
OMI were more similar to that of the general public. Students' attitudes, while similar to the experts in regard to factors of authoritarianism, benevolence, and social restrictiveness were markedly different for the factors of mental health ideology and interpersonal ideology. Results of the comparison between undergraduate and graduate students revealed graduate students endorsed a greater belief that the mentally disabled pose a threat to society. Comparison of all other factors revealed no statistically significant difference in belief.
Appendix A

Mental Health Information Questionnaire
Instructions:
You are being asked to participate in a study of mental health problems. Your participation will supply valuable information to those responsible for the nation’s health.

On the following pages you will find a number of statements about health problems. We want to know how much you agree or disagree with each of the statements. To the right of each statement you will find a rating scale. The points on the (1,2,3,4,5,6,7) can be interpreted as follows:

1. Completely disagree
2. Mostly disagree
3. Disagree more than agree
4. Neutral
5. Agree more than disagree
6. Mostly agree
7. Completely agree

Like everyone else, you will probably feel that you do not know the answer to some of the statements. When this occurs please make the best guess that you can.

Please make sure that you make a mark for each statement. Leave none of the statements blank and make only one mark for each statement. You should not spend more than a few seconds marking each statement. If it is difficult for you to make up your mind, make the best guess that you can and go on to the next one.

5. People cannot maintain good mental mental without the support of strong persons in their environment. 1 2 3 4 5 6 7
6. Will power alone will not cure mental disorders.

7. Women have no more emotional problems than men do.

8. X-rays of the head will not tell whether a person is likely to become insane.

9. Emotional problems do little damage to the individual.

10. Psychiatrists try to teach mental patients to hold in their strong emotions.

11. Mental illness can usually be helped by a vacation or a change of scene.

12. Disappointments affect children as much as they do adults.

13. The main job of the psychiatrist is to recommend hobbies and other ways for the mental patient to occupy his time.

14. The insane laugh more than normal people.

15. Psychiatrists try to show the mental patient where his ideas are incorrect.

16. Mental disorder is not a hopeless condition.

17. Mental health is one of the most important national problems.

18. Mental disorder is usually brought on by physical causes.

19. It is easier for women to get over emotional problems that it is for men.

20. A change of climate seldom helps an emotional disorder.

21. The best way to mental health is by avoiding morbid thoughts.
22. There is not much that can be done for a person who develops a mental disorder.

23. Mental disorder is one of the most damaging illnesses that a person can have.

24. Children sometimes have mental breakdowns as severe as those of adults.

25. Nervous breakdowns seldom have a physical origin.

26. Most of the people in mental hospitals speak in words that can be understood.

27. Mental health is largely a matter of trying hard to control emotions.

28. If a person concentrates on happy memories he will not be bothered by unpleasant things in the present.

29. The mentally ill have not received enough guidance from the important people in their lives.

30. Women are as emotionally healthy as men.

31. The seriousness of the mental-health problem in this country has been exaggerated.

32. Helping the mentally ill person with his financial and social problems often improves his condition.

33. Mental patients usually make a good adjustment to society when they are released.

34. The good psychiatrist acts like a father to his patients.

35. Early adulthood is more of a danger period for mental illness than later years.

36. Almost any disease that attacks the nervous system is likely to bring on insanity.
37. You can tell a person who is mentally ill from his appearance.

38. People who become mentally ill have little will power.

39. Women are more likely to develop mental disorders than men.

40. Most mental disturbances in adults can be traced to emotional experiences in childhood.

41. People who have little sexual desire are more likely to have a "nervous breakdown" than are other people.

42. A person can avoid worry by keeping busy.

43. A poor diet often leads to feeble mindedness.

44. Emotionally upset persons are often found in important positions in business.

45. Good emotional habits can be taught to children in school as easily as spelling can.

46. The eyes of the insane are glassy.

47. When a person is recovering from a mental illness, it is best not to discuss the treatment that he has had.

48. People who go from doctor to doctor with many complaints know that there is nothing really wrong with them.

49. A person cannot rid himself of unpleasant memories by trying hard to forget them.

50. The main job of the psychologist is to explain to the patient the origin of his troubles.

51. Most suicides occur because of rejection in love.
52. People who are likely to have a nervous breakdown pay little attention to their personal appearance.

53. Most of the time psychiatrists have difficulty in telling whether or not a patient's mental disorder is curable.

54. Children usually do not forget about frightening experiences in a short time.

55. Books on "peace of mind" prevent many people from developing nervous breakdowns.

56. Most clergymen will encourage a person with a mental disorder to see a psychiatrist.

57. Physical exhaustion does not lead to a nervous breakdown.

58. The adult who needs a great deal of affection is likely to have had little affection in childhood.

59. Physical rest will not prevent a mental disorder.

60. Most of the people who seek psychiatric help need the treatment.

Appendix B

Opinions About Mental Illness Scales
Directions:

The statements that follow are opinions or ideas about mental illness and mental patients. By mental illness, we mean the kinds illness which bring patients to mental hospitals, and by mental patients we mean mental hospital patients. There are many differences of opinion about this subject. In other words, many people agree with each of the following statements while many people disagree with each of the statements. We would like to know what you think about these statement. Each of them is followed by six choices:

strongly-agree--not sure but probably--not sure but probably--disagree--strongly agree 
agree 
disagree 
disagree

Please mark (X) in the space provided that choice which come closest saying how you feel about each statement. You can be sure that many people including doctors will agree with you choice. There are no right or wrong answers: we are interested only in you opinion. It is very important that you answer every item. Please do NOT sign your name.

1. Nervous breakdowns usually result when people work to hard.

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree 
agree 
disagree 
disagree

2. Mental illness is an illness like any other.

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree 
agree 
disagree 
disagree

3. Most patients in mental hospitals are not dangerous.

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree 
agree 
disagree 
disagree

4. Although patients discharged from mental hospitals may seem all right, they should not be allowed to marry.

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree 
agree 
disagree 
disagree
5. If parents loved their children more, there would be less mental illness.

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree agree disagree disagree

6. It is easy to recognize someone who once had a serious mental illness.

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree agree disagree disagree

7. People who are mentally ill let their emotions control them: normal people think things out.

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree agree disagree disagree

8. People who were once patients in mental hospitals are no more dangerous than the average citizen.

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree agree disagree disagree

9. When a person has a problem or a worry, it is best to think about it, but keep busy with more pleasant things.

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree agree disagree disagree

10. Although they usually aren’t aware of it, many people become mentally ill to avoid the difficult problems of everyday life.

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree agree disagree disagree

11. There is something about mental patients that makes it easy to tell them from normal people.

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree agree disagree disagree
12. Even though patients in mental hospitals behave in funny ways, it is wrong to laugh about them.

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree 
agree 
agree 
disagree 
disagree

13. Most mental patients are willing to work.

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree 
agree 
agree 
disagree 
disagree

14. The small children of patients in mental hospitals should not be allowed to visit them.

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree 
agree 
agree 
disagree 
disagree

15. People who are successful in their work seldom become mentally ill.

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree 
agree 
agree 
disagree 
disagree

16. People would not become mentally ill if they avoided bad thoughts.

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree 
agree 
agree 
disagree 
disagree

17. Patients in mental hospitals are in many ways like children.

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree 
agree 
agree 
disagree 
disagree

18. More tax money should be spent in the care and treatment of people with severe mental illness.

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree 
agree 
agree 
disagree 
disagree
19. A heart patient has just one thing wrong with him, while a mentally ill person is completely different from other patients.

Strongly-agree--not sure but probably--not sure but probably--disagree--strongly agree
agree disagree disagree

20. Mental patients come from homes where the parents took little interest in their children.

Strongly-agree--not sure but probably--not sure but probably--disagree--strongly agree
agree disagree disagree

21. People with mental illness should never be treated in the same hospital with people with physical illness.

Strongly-agree--not sure but probably--not sure but probably--disagree--strongly agree
agree disagree disagree

22. Anyone who tries to better himself deserves the respect of others.

Strongly-agree--not sure but probably--not sure but probably--disagree--strongly agree
agree disagree disagree

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

Strongly-agree--not sure but probably--not sure but probably--disagree--strongly agree
agree disagree disagree

24. A woman would be foolish to marry a man who had a severe mental illness, even though he seems fully recovered.

Strongly-agree--not sure but probably--not sure but probably--disagree--strongly agree
agree disagree disagree

25. If the children of mentally ill parents were raised by normal parents, they would not become mentally ill.

Strongly-agree--not sure but probably--not sure but probably--disagree--strongly agree
agree disagree disagree
26. People who have been patients in a mental hospital will never be their old selves again.

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree agree disagree disagree

27. Many mental patients are capable of skilled labor, even though in some ways they are very disturbed mentally.

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree agree disagree disagree

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

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree agree disagree disagree

29. Anyone who is in a hospital for a mental illness should not be allowed to vote.

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree agree disagree disagree

30. The mental illness of many people is caused by the separation or divorce of their parents during childhood.

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree agree disagree disagree

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

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree agree disagree disagree

32. To become a patient in a mental hospital is to become a failure in life.

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree agree disagree disagree
33. The patients in mental hospitals should be allowed more privacy.

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree agree disagree disagree

34. If a patient in a mental hospital attacks someone, he should punished so he doesn’t do it again.

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree agree disagree disagree

35. If the children of normal parents were raised by mentally ill parents, they would probably become mentally ill.

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree agree disagree disagree

36. Every mental hospital should be surrounded with a high fence and guards.

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree agree disagree disagree

37. The law should allow a woman to divorce her husband as soon as he has been confined in a mental hospital with a severe mental illness.

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree agree disagree disagree

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

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree agree disagree disagree

39. Mental illness is usually caused by some disease of the nervous system.

Strongly--agree--not sure but probably--not sure but probably--disagree--strongly agree agree disagree disagree

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
40. Regardless of how you look at it, patients with severe mental illness are no longer really human.

41. Most women who were once patients in a mental hospital could be trusted as baby sitters.

42. Most patients in mental hospitals don't care how they look.

43. College professors are more likely to become mentally ill than are business men.

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

45. Although some mental patients seem all right, it is dangerous to forget for a moment that they are mentally ill.

46. Sometimes mental illness is punishment for bad deeds.
47. Our mental hospitals should be organized in a way that makes the patient feel as much as possible like he is living at home.

Strongly-agree--not sure but probably--not sure but probably--disagree--strongly agree
agree disagree disagree

48. One of the main causes of mental illness is a lack of moral strength or will power.

Strongly-agree--not sure but probably--not sure but probably--disagree--strongly agree
agree disagree disagree

49. There is little that can be done for patients in a mental hospital except to see that they are comfortable and well-fed.

Strongly-agree--not sure but probably--not sure but probably--disagree--strongly agree
agree disagree disagree

50. Many mental patients would remain in the hospital until they were well, even if the doors were unlocked.

Strongly-agree--not sure but probably--not sure but probably--disagree--strongly agree
agree disagree disagree

51. All patients in mental hospitals should be prevented from having children by a painless operation.

Strongly-agree--not sure but probably--not sure but probably--disagree--strongly agree
agree disagree disagree

Appendix C

Introduction Letter
Dear Chairperson:

I am a graduate student in the occupational therapy department at Western Michigan University. I am interested in the attitudes of occupational therapy students about the mentally disabled.

I am writing to request your assistance with my proposed research. Your participation would be voluntary and greatly appreciated. Although you may agree to participate, final selection for this project will be random.

The proposed study involves the administration of 2 questionnaires: Opinions About Mental Illness Scales and Mental Health Information Questionnaire. Your participation requires you to communicate with the appropriate faculty member in order to request his/her assistance in the distribution and collection of the above questionnaires. The questionnaires would be administered to undergraduate or graduate occupational therapy students. The students’ participation is also voluntary. The faculty member should verbally indicate that participation is voluntary and that non-participation will not be penalized. Also, if at any time the student wishes to terminate participation, he/she may exit the room without penalty.

Once the questionnaires are completed and placed in a large envelope by the participating students, I would require them to be sealed in the envelope and returned to my advisor via Federal Express. No faculty members should review the instruments prior to their off-campus mailing. All materials and postage will be provided for you.

Again, I would like to stress there is no way in which I or my advisor will be able to identify anyone participating in this research. Also, the responses to the questionnaires will not be shared with anyone other than myself and my advisor.

If you would like to participate, please return the enclosed postcard by 3/21/92. This postcard will document your response to my request. If you wish to contact me directly, correspondence may be sent to the following address:

Patricia McCarthy
126 Federal Court
Kalamazoo, MI 49007
616-349-5830

Again, I would greatly appreciate your assistance and look forward to hearing from you.

Sincerely,

Patricia McCarthy
Appendix D

Cover Letter
Dear Student:

I am a graduate student in the occupational therapy department at Western Michigan University. I am interested in the attitudes of occupational therapy students about the mentally disabled.

Your participation in this study is voluntary and greatly appreciated. Two questionnaires used to assess attitudes toward psychiatric conditions will be distributed to you. Part 1 asks for general demographic data about you. Part 2 will consist of the questionnaire. Completion of these questionnaires will take approximately 30-45 minutes.

To complete this questionnaire, I do not require your name and there is no means by which I can discover your identity. No one will be able to identify you. Participation is voluntary and non-participation will not be penalized. Also, if at any time you wish to terminate participation, you may exit the room without penalty.

When you have finished answering all the questions, please place the questionnaires in the envelope provided for you. No one will see the completed questionnaires except for myself and my advisor.

By completing these questionnaires, you will be helping both myself and the profession of occupational therapy. Resulting from you assistance will be a better understanding of the attitudes toward the mentally disabled and the implications of these attitudes toward the practice area of mental health. Again, I greatly appreciate your participation.

Sincerely,

Patricia McCarthy
Appendix E

Human Subjects Institutional Review
Board Letter of Approval
Date: February 18, 1992

To: Patricia McCarthy

From: Mary Anne Bunda, Chair

Re: HSIRB Project Number 91-12-12

This letter will serve as confirmation that your research protocol, "Occupational therapy students attitudes toward the mentally disabled" has been approved after full review by the HSIRB. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the approval application.

You must seek reapproval for any change in this design. You must also seek reapproval if the project extends beyond the termination date.

The Board wishes you success in the pursuit of your research goals.

xc: Hemphill, OT

Approval Termination: February 18, 1992
BIBLIOGRAPHY


Weiss, M. F. (1985). Children's attitudes toward mental illness as assessed by the opinions about mental illness scale. Psychological Reports, 57, 251-258.


