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A SURVEY OF THE ROGERS PARK-WEST RIDGE AREA SHOWING THE
RELATIONSHIP OF PERCEIVED MENTAL HEALTH NEEDS, ATTITUDES
TOWARD MENTAL ILLNESS AND SELECTED DEMOGRAPHIC VARIABLES

By

Barbara J. Dydyk

A Thesis Submitted to the Faculty of the Graduate School
of Loyola University in Partial Fulfillment of
the Requirements for the Degree of
Master of Arts

May

1971

LIFE

Barbara J. Dydyk was born in Sudbury, Ontario, Canada on May 6, 1946.

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ACKNOWLEDGEMENTS

The author wishes to express her gratitude to Dr. John Shack and Dr. Jim Johnson who encouraged the author's initial inquiry into the field of community psychology and who directed this thesis.

The assistance given by the students of Loyola University and Mundelein College in the survey and collection of data for this thesis research is also greatly appreciated.

TABLE OF CONTENTS

Chapter	Page
I. INTRODUCTION	1
II. METHOD	20
III. RESULTS	27
IV. DISCUSSION	36
V. SUMMARY	41
REFERENCES	43
APPENDIX A	48
APPENDIX B	53
APPENDIX C	56
APPENDIX D	57
APPENDIX E	58
APPENDIX F	59

LIST OF TABLES

Table	Page
1. Means and Standard Deviations of the Perceived Need Scores of the Rogers Park-West Ridge Community.....	28
2. Means and Standard Deviations of Attitudes Toward Mental Illness of the Rogers Park-West Ridge Community	29
3. Means and Standard Deviations of the Demographic Variables of the Rogers Park-West Ridge Community..	30
4. Relationship Between Attitudes Toward Mental Illness and the Perceived Mental Health Needs of the Rogers Park-West Ridge Community	31
5. Relationship of Demographic Variables and Perceived Mental Health Needs of the Rogers Park-West Ridge Community	33
6. Relationship Between Attitudes Toward Mental Illness and Demographic Variables of the Rogers Park-West Ridge Community	34

CHAPTER I

INTRODUCTION

A group of people is idiosyncratic in its reservoir of beliefs, attitudes and values. These are rooted in the unique history and tradition of the people and in their individual characteristics. It is these qualities that will ultimately affect how each community comes to deal with the issues and concerns confronting its inhabitants. Before one can gain a clear picture, however, of how a community deals with its concerns it is necessary to examine the perception a community has of its priority of needs and its attitudes. This is relevant particularly in the area of community mental health planning.

Within the Rogers Park-West Ridge area, on Chicago's north shore, a community mental health program is being developed. The State of Illinois and the city of Chicago have united in the initial planning of this program. Some of the groundwork has been laid by the North Town-Rogers Park Mental Health Council, composed of interested private citizens, of representatives from the city and the state and associations within the community. While outlining a program of community mental health services, this community found a dearth of information about the needs and the priorities of its citizens and about areas of support and/or resistance for their proposals. Also lacking was information about existent services within the community.

This study, therefore, surveys the population of the Rogers Park-West Ridge Community in order to determine existing attitudes towards mental illness, to assess the perception the community has of its mental health needs and to explore the relationship among these and, in turn, with certain select demographic variables.

In planning for mental health services the need for community involvement is of great importance. Hume (1966, p.523) identified one goal of a community psychiatric program as "surveying a community's resources and needs with respect to mental health services." One ingredient suggested by Rieman (1969, p. 43) for effective community mobilization is "local involvement in depth in problem appraisal, the development of priorities and the implementation of services." He describes how surveying members of the community with regard to their priorities, attitudes and opinions regarding mental health constituted a basic factor in the success his group experienced in implementing community mental health services.

In a ten year mental health research program in Wellesley, Massachusetts, conducted by Klein (1968) survey techniques were considered most beneficial in helping to pinpoint the distribution of mental health resources that were being used, to what extent and by whom. Key (1969) as a result of data gathered from interviews done on Urban Renewal Area residents, was able to warn Urban Renewal planners of forthcoming difficulties in the way of resistances and

sources of resistance to their program. And Weissman (1969, p. 155-156) stated, in describing the development of mental health services in New York's Lower East Side, that "The neighborhood services centers began with the idea that they were going to meet the needs of the clients as the clients defined them. The centers would thus avoid the professional trap of defining the needs of the clients in terms of the professional's expertise." Kellan and Schiff (1968) claim success in the development of community mental health services in the Woodlawn area in Chicago. Their goals strongly embraced involvement of the community; they stated:

We now had a commitment to the community of Woodlawn for a minimum of five years to collaborate with the community to accomplish the following goals:

1. to assess the mental health needs of this urban neighborhood community.
2. to assess the resources available to meet these needs of this urban community.
3. to establish with the community a system of priorities that would indicate the sequence of problems to attack.
4. to develop with the community's support mental health programs directed at top priority problems.

According to Smith and Hansell (1967) however, large scale community evaluation programs do not set a positive example of well-executed studies. This is due in part to the absence of carefully controlled lab environments, to difficulties in identifying and controlling all the important variables involved, and to an inability to meet the criterion of scientific method. Programs investigated apparently included

vaguely defined goals, lack of technical knowledge as to what data are most relevant for development of community programs and an absence of those skills needed for the utilization of data for program development (Moore, Bloom and Gaylin, 1967). However, it would seem essential that well-done evaluative research be viewed as playing a crucial role in the establishment of any community program. Research in the past would appear to have involved an over-emphasis on the traditional type of information about patients to the exclusion of data "that more nearly defines the mental health needs of the entire community" (Moore et al., p. 31).

What is of primary importance is the analysis of prevailing public attitudes. For example, in one state community leaders did not perceive mental illness to be a large-scale community problem. Rather, community mental health planners, after studying community attitudes, instead of initiating plans for the immediate establishment of a mental health center gave priority to the development of an intensive program to inform and educate the public. Bahn (1965, p. 25) states, "attitude research can provide the basis of specific goal-oriented mental health education programs... ..since the ability to recognize overt signs and symptoms of mental illness in oneself and others and seek and accept diagnosis and treatment when indicated are selective factors which influence specific pathways to care. Differences in the rate of psychiatric care may be as much due to differences in the degree of recognition of mental illness and to

modes of dealing with it as to variations in the extent of disability in the population." Attitudes such as tolerance within a community to deviant behavior may thus affect the severity of symptoms and requirements for hospitalization.

Klein (1965) formulates a simple conceptual framework for the assessment of the dynamics of a community and includes among what he calls "the rubrics;" the location, that is, the geographic location, the physical characteristics and internal arrangements of such as roads, industries, institutions, etc.; the self-image of the community, as reflected in and formed by the "sentiments" or attitudes and values of the community inhabitants; the social-psychological structure as indicated by significant groupings varying in authority, or prestige and power, in their respective duties and in the communication patterns established between them; and lastly, what he labels "the dynamic interplay of forces." This reflects the community as a total system that resists or absorbs new values and forces and shapes both the nature or certain life stresses and the kind of support that is available to the people. Klein emphasized that the community's "phenomenology," its distinctive way of viewing itself, leads to a variety of reactions toward the introduction of mental health programs. This self-image can frequently reveal divergent and conflictual values within a single community. As well, the social-psychological structure, based on demographic variables such as nationality, religion, educational

level, occupational pursuits, etc. appears to alter both awareness of any existent problems and the appropriate utilization of what community resources are present. Klein (1968) documents, furthermore, that organized programs under mental health auspices have tended to be supported largely by upper-middle class members, composed of a high proportion of young families with children.

Klein (1968) emphasized two other important aspects of community research which when taken into consideration can alleviate many of the problems that accompany mental health research: first, recall that a basic fear to individuals and societies is threat to one's security and that when change agents functioning within a community mental health movement seek to introduce new elements into the life of the community what results is a kind of resistance that serves a defensive function. Implementers of community mental health programs must thus proceed with caution and awareness of this protective mechanism; more important, however, and relating to Klein's definition of community as "patterned interactions within a domain of individuals seeking to achieve security and physical safety, to derive support at times of stress and to gain selfhood and significance throughout the life cycle" is the recognition of one of the community's basic functions as providing for the many and varied needs of the inhabitants. This is assessed through a consideration of what present needs are being met and why.

In a program developed by Whittington (1960) his initial strategy involved meeting the community's perceived needs as rapidly as possible via other caregiving agencies and learning about mutual needs, expectations and misperceptions. Given the groundwork established by surveys, understanding and cooperation, Whittington points out that efforts can then better be made to refocus misperceptions and expectations of the community into more realistic areas.

Much of the research done on community attitudes has dealt with how the mentally ill are perceived by the public, with the emphasis on attitude change. Past studies (Allen, 1943; Bingham, 1951; Proceedings of the 12th Annual Conference on Public Opinions Research, 1957) have shown that public feeling about the mentally ill is characterized by anxiety, fear, stigmatization, rejection and misinformation, (Cummings and Cummings, 1956; Nunnally, 1961; Ramsey and Seipp, 1948; Starr, 1969; Woodward, 1951). Cummings and Cummings (1951) hold a theory of social response to the mentally ill as comprising the sequence of denial, isolation and rejection.

However, a study carried out in Baltimore (Roper, 1960) showed the population to be both well-informed and to verbally express both tolerant and understanding feelings toward the mentally ill. Roper's study and one by Woodward (1950) point to what these researchers conceive of as a change in popular attitudes toward mental health. Given that the change is in

the positive direction this would seem to provide more fertile territory for the initiation of community mental health programs. However, Rootmann and Lafave (1969) in a study done in a Canadian rural town compared current attitudes toward the mentally ill with findings from a similar town in 1951. Although there appeared to be a greater knowledge of mental illness and more sophistication about it, the authors were cautious to point out that attitudes expressed during the interviews were at variance with the individual's actual behavior toward the mentally ill. Yamamoto and Digny (1968) point out that individuals do not "translate" whatever abstract knowledge of mental health principles they have in their possession into appropriate responses in concrete situations (see also Davis, 1965). This concurs with Bahn's statement (1965, p. 28) that this type of research is most difficult to evaluate, since it involves "motivational aspects and putative attitudes" and thus would not seem to present an entirely accurate picture.

A study done by Lemkau and Crocetti (1962) in attempting to explore the readiness of a population to accept a program to provide home care to psychiatric patients indicated that there was little rejection, as Cummings postulated, towards an identified mentally ill individual. What was postulated was a change in the perceptual context in which the public views mental illness, the person being seen at present as more of a "social transgressor" and less of a "sick" person. It would thus seem that according to this study society is

more able to distinguish between behavior determined by socio-cultural factors and mental illness.

Phillips (1967) concurs with Lemkau and Crocetti's (1962) and Dohrenwend's (1962) findings that the public is more able to recognize and to identify mental illness, but questions the significance of such in the light of whether this in fact produces a positive change in the public attitude toward the mentally ill. If the community considers individuals described in the abstracts provided in the above studies to be mentally ill and not difficult or ill-mannered, or socially deviant, those authors appear to presume that the public will therefore change in the manner of response to people showing the same behavior in real life situations. Phillips (1966) found that although it would seem that the public ought to be more understanding and more supportive of people defined by the characteristic label, that the increased ability to identify mental illness seemed to have consequences directly opposite to those considered. No positive action was implied. Johannsen (1969) found in an experiment with college students, wherein subjects were led to believe that their partner was mentally ill, that the supposedly mentally ill person was considered to have hindered performance even though the former's performance improved; the "sick" co-workers were judged to be less liked and the students were somewhat unwilling to work with them. Nunnally (1961) found, using the semantic differential, that the mentally ill were regarded as "worthless, dirty, dangerous, cold and unpredictable." He appropriately

differentiated between attitude and information, the latter referring to "verifiable statements in which the question of truth or falsity is involved" and the former to "a personal disposition avoiding truth as an issue." Nunnally (in Johannsen, 1969) also found that the general public is not in fact grossly misinformed about the facts regarding mental illness but the average citizen showed some uncertainty, however, being more "uninformed than misinformed." Johannsen (1969, p. 228) states in commenting on Nunnally's work, "When attitudes are probed conclusions are alarming though not unexpected."

Another finding of Johannsen (1969) related to the fact that society is quite tolerant of behavior considered deviant provided that it is not labelled an example of mental illness. People will excuse an individual's quirks, eccentricities and aberrant behavior. Cummings and Cummings (1951) explain this on the basis of citizens accustomed to talking in rather concrete cause and effect terms when explaining disruptive or otherwise unusual behavior. Thus, such behavior is explained as due, for example, to cruelty in one's youth, poor infantile care, etc. A community is concerned as well with the maintenance of its "functioning and the preservation of its social fabric." It is denied that a citizen is behaving deviantly, this permits society to retain a semblance of integrity. However, should the behavior become extremely unpredictable such that it cannot be ignored, isolation in a mental hospital occurs and thus the label "mental patient" comes to imply

that the individual was never fully functioning and the community is thus rid of its responsibility. Both Cummings and Cummings (1951) and Johannsen (1969) imply that society sees the mental patient as representative of all its unpredictable elements, using the method of institutionalization as a mode of labelling these negatively valenced elements for more facile identification in the future.

Given, therefore, that each society is coloured by a particular tone of attitude toward the mentally ill, it would seem that just as is indicated, this bears a relationship to the manner in which the mentally ill are treated. In a like manner it is postulated therefore that prevailing attitudes will colour the perception of the community's needs, particularly since many of the needs are pertinent to the care of the mentally ill. Such attitudes affect the initiation of a community mental health program.

Numerous studies have been done relating mental health attitudes to particular variables. It has been shown that attitudes toward mental health and illness are determined by factors such as cultural background (Arkoff, Thaver, and Elking, 1966; Clausen, 1965; Nikelly, Sugita and Otis, 1964; Thaver, Arkoff and Elking, 1965; Wallace, 1961), by personal, familial or community experience with mental illness (Clausen and Yarrow, 1955; Marston and Levine, 1963; Wright and Shrader, 1965), by certain personality constellations (Marston and Levine, 1963) and by social roles or frames of reference

(Berlin, 1959; Hartlage, 1966). More pertinent to this paper are those studies dealing with attitudes as a function of the demographic variables of occupation, education, age, sex and nationality.

Cohen and Struening (1962) studied the relationship between their Opinions About Mental Illness Questionnaire (utilized in this study) and the variables of occupation, education, age and sex for two VA hospital samples. They discovered a striking difference in orientation towards the mentally ill among the various occupational groups, aids being at opposite extremes from mental health professions. On "Authoritarianism" (Factor A) and "Benevolence" (Factor B)* psychiatrists, psychologists and social workers had low scores, with aids high, indicating the former were least authoritarian and benevolent. On "Benevolence" special service personnel, nurses and ward clerical personnel were also high. This would imply, according to Cohen and Struening that psychologists reject the moralistic-paternalistic aspect of Factor B. On Factor C, "Mental Health Ideology," aids showed the lowest scores and social service workers the highest; a similar pattern was evident on Factor E (Interpersonal Etiology). Social Restrictiveness, (Factor D) did not strongly separate the groups.

Regarding level of education, there was a significant negative correlation with "Authoritarianism," a weaker but significant inverted U-shaped relationship with "Benevolence,"

*These factors are defined in the Procedural Section under "Instruments"

the peak coming in the "some college group" and a strong positive relationship with "Mental Health Ideology," thus supporting this factor as the mental health professionals' creed. As well, there was a non-significant relationship with "Social Restrictiveness" and a significant but weak relationship with "Interpersonal Etiology."

The variable, age, did not relate as strongly as the previous two variables, neither Factor B,C or E being significantly related. "Authoritarianism" showed a weak, slow increase with age. Sex, as well, was only weakly related to factor scores, there being no significant relationship with "Authoritarianism, Mental Health Ideology or Interpersonal Etiology." Women did show somewhat higher "Benevolence" scores than men, in keeping with cultural demands, and higher "Social Restrictiveness" scores. This latter was postulated to be an artifact. The authors thus postulated that the difference in factor scores found as one goes up the occupational-educational hierarchy of the two sampled mental hospitals accounts to some extent for the friction between professional groups in hospitals and for failures in communication between those who give and those who carry out orders. Because of the particular population utilized results are not generalizable, but the greatly disparate views of the nature and progress of mental illness held by these individuals must be taken into consideration when dealing with the general population.

Social class, according to Hartlage (1966) and Freeman (1961) is not a determinant of attitudes regarding mental illness. Education is, however, frequently implicated and it

would seem that educated people tend to have less derogatory attitudes and be more tolerant of contact with the mentally ill than the less educated. (Nunnally, 1961; Cummings and Cummings, 1957). In a study performed on a large Washington sample (Freeman, 1961) contrary evidence was found. It would seem that in their survey of the public's conception of mental illness, done on a sample of 483 people, using "yes-no" and open-ended questions, that there was a zero-order correlation between education and knowledge and opinions about mental illness. As well, Altrocchi and Eisdorfer's (1961) population appeared to have a greater level of information about mental illness than the general population and yet did not show markedly different attitudes. They postulated that although subjects might possess higher educational achievement and intelligence and an upper or middle socio-economic status, that increasing information about mental illness is not sufficient for attitude change, contact with the mentally ill being of primary importance.

Nunnally (1961, p. 15) suggests, to account for this discrepancy, that individuals with at least some high school training are "discernibly different from those with none, additional schooling affecting attitudes only slightly." Cummings and Cummings (1957, p. 12) suggest that "younger, better-educated people who live in medium and high rental areas are more likely to assume social responsibility for the mentally ill and to accept greater social contact with them." They postulated

that older people with less education and a prevalent tendency to more "puritanical views of personal excellence" seem to accept less social contact with the mentally ill and thus feel less responsible for social problems within their own area. Clark and Bink's study (1966) using the Custodial Mental Illness Ideology Scale, also found younger and more educated members of their community to hold more liberal views of mental illness and its treatment; they felt that these views are less self-evident, particularly since older people are more tolerant because of their lengthier experience.

With regard to nationality or ethnic group differences, Suchman (1964) found significant variations in knowledge about disease and in attitudes toward illness and medical care. These differences, however, were found to be related to the form of the social organization within the ethnic group and less to the specific ethnic group. The more ethnocentric and socially cohesive the group on a community, friendship or family level, the more likely are its members to display low knowledge about disease, skepticism about professional medical care and dependency during illness. Clark and Binks (1966) found in their study, in keeping with the above, that their subjects' attitudes were more congruent with those of the major group be this the family, work or associational group to which they belonged.

With regard to the occupational variable, Mackey (1969) in studying the personal concepts of the mentally ill among

caregiving groups, (this included social workers, psychologists, psychiatrists, police officers, welfare workers, and guidance counselors) found that people in particular occupations have expectations about their roles in relation to mental illness, and express a great deal of variability regarding its meaning. Thus, for example, police officers enforce the law and deal with much deviance, particularly in the form of antisocial behavior; it is usual for them therefore, to associate mental illness with aggressive behavior. On the other hand, mental health agents because they are expected to think of people in highly individual terms are unable to generalize about any behavior and approach mental illness on a highly individualistic level. And public welfare social workers identify mental illness with psychotic-like behavior more extensively than others. Johannsen (1969) found that a problem in research in this area lay in defining the concept of "mental illness" since this is essentially a layman's term and takes on a variable meaning when used by a layman as compared to a mental health professional. For example, Johannsen found that the former refer to it as a condition that results in confinement in a psychiatric hospital and the latter as a functional psychosis.

Nunnally (1961) found that general medical practitioners, although possessing accurate information about etiology, symptomology and prognosis about mental illness nonetheless manifest attitudes towards mental patients similar to those of the

general public. He sees, however, a trend to a more positive evaluation of mental illness among younger practitioners.

In a similar vein, Olshansky, Grab and Malamud (1958) studied employers' attitudes towards mental illness in a rather extensive carefully controlled study in Boston and found their attitudes to be more negative and quite similar to that of the general public in that they regarded mental illness as a character weakness.

In a lower middle-class New York neighborhood (Johannsen, 1969) the attitudes of local leaders were examined; it appeared that educational leaders showed far more sensitivity to mental illness, seeing it as serious and assisting in alleviating the distress when such was brought to their attention. Economic leaders were less aware of symptomatology and its degree of seriousness, whereas political leaders had attitudes comparable to those of the educational leaders; they were fairly well-informed, since it was somewhat necessary for them as well, to know where a referral might be made. Dohrenwend (1962) found that religious leaders tended to regard behavioral anomalies as serious, but were less aware that these were symptoms of mental disorders and thus had little proclivity to refer people for professional help. Catholic clergy (Larson, 1965) were found to have more negative attitudes and unrealistic presumptions regarding mental illness than Protestant ministers.

Klein (1965) declares that there appears to be a relatively greater receptivity on the part of the educational and

certain religious systems, antagonism and direct provocation on the part of law and order exponents, and avoidance of issues by those individuals concerned with maintenance of cherished community values such as real estate and land values, neighborhood integrity, etc. Johannsen (1969) found that the law's treatment of the mentally ill plays a significant part in the formation of society's opinions.

Important in considering the exploration of a community and its attitudes towards mental illness and perceived needs is Nunally's statement (1961, p. 15) that "People in general have a moderate interest in mental health and therefore some receptivity to information about mental health." He continues that society is most involved with the immediate and closest aspects of mental illness, this divorced from the social aspects. He believes accordingly that if information is available geared to reducing immediate fears and offering information about the causes and early signs of mental illness, that data will be sought out and attitudes possibly altered.

Within the area of assessment of mental health needs within a community there would appear to be a dearth of studies. Yet it would appear that the perception of the need priority in the realm of mental health would be of primary importance as indicated in the previous references of Kellan and Schiff (1968), Weissman (1969) and Klein (1968). This study will thus in part address itself to exploring the area of mental health need priority of the Rogers Park-West Ridge community.

In summary, therefore, this study will be concerned with the following three issues within the Rogers Park-West Ridge community:

1. The relationship of perceived mental health needs and prevailing mental health attitudes;
2. The relationship of perceived mental health need priority and selected demographic variables;
3. The relationship of the community's mental health attitudes and selected demographic variables.

CHAPTER II

METHOD

Subjects.--Approximately 300 randomly selected citizens of the Rogers Park-West Ridge community were interviewed. Rogers Park is twelve miles north of Chicago's Loop area in the most extreme corner of northeastern Chicago.

Instruments.--The attitude survey used was the Opinions about Mental Illness Questionnaire, developed by Cohen and Struening (1959). It consists of a 51 item scale of a Likert-type, measuring attitudes toward the causes and treatment of mental illness. The questionnaire includes items from the Custodial Mental Illness Ideology Scale (Gilbert and Levinson, 1956), the California F scale (Struening, 1957) and statements from Nunnally's studies on popular conceptions of mental health. Response is made on the original scale on a six point Likert-type scale; revision was made in this study to a five point scale with a middle neutral point. This scale was designed for group administration based on an original sample of 8,248 persons employed in twelve Veterans Administration Hospitals across the United States. The questionnaire is based on the belief that opinions about the mentally ill are "potentially multi-dimensional and the number and nature of these dimensions is an empirical issue, not one to be assumed in advance." Attitudes are defined in this study to be "variables which carry an affective or an adient-avoidant valence" and factors A through D reflect attitudes while factor

E is an opinion factor. The questionnaire contains the following five factors:

Factor A: Authoritarianism: which includes authoritarian submission and anti-intracception, in addition to a view of the mentally ill as an inferior class requiring coercive handling; it compares significantly with the California F scale. It is a dominant factor which accounts for 47% of the common variance.

Factor B: Benevolence: which is defined as a "kindly paternalistic view towards patients whose origins lie in religion and humanism rather than in science. This view can be considered to be encouraging and nurturant but still acknowledges some fear of patients. It accounts for 15% of the variance.

Factor C: Mental Health Ideology: which is defined as a "positive orientation embodying the beliefs of modern mental health professionals and the mental health movement, that mental illness is an illness like any other." It is in sharp contrast to the Factor A orientation. Implicit, therefore, is the belief that mental patients are much like normal people, differing in degree but not in kind. It accounts for 14% of the variance.

Factor D: Social Restrictiveness: is based on the belief that the mentally ill are a threat to society and particularly the family, and that they must thus be restricted in function during and after hospitalization. There would appear to be a certain similarity between Factor A and Factor D.

Factor E: Interpersonal Etiology: The positive pole of this factor reflects the belief that mental illness arises from interpersonal experience, especially deprivation of parental love during childhood. Less central is the belief that abnormal behavior is motivated. This factor accounts for 10% of the shared variance.

The attitude survey questionnaire can be found in Appendix A. The needs survey questionnaire was based on the six developmental periods of infancy, childhood, adolescence, early and middle adulthood and old age, (based on Lidz, 1968). Specific needs unique to each area were listed to be ranked on a five point scale from strongly agree (1) to strongly disagree (5)

by each respondent on the basis of how he perceived each need. Specialists in the area of developmental psychology and community psychology cross-checked the applicability of the need questionnaire to the Rogers Park Community. The needs specific to each area can be found in Appendix D. The completed need survey questionnaire can be found in Appendix B.

In the light of the need to provide some check on the scaled perception of needs, respondents were also asked to list on a separate sheet (see Appendix C) those needs they thought most important for each of the above six areas.

A demographic data questionnaire was added with the provision that individuals surveyed feel under no obligation to complete it. Optional responses were to be made pertaining to place of birth, length of residence in Rogers Park, and Chicago, age, marital status, number of children and their ages, education and occupation. Two additional questions were asked pertaining to what one felt to be the function of a community mental health center and how one felt about the introduction of such a center in the community. This was added as a cross-check on both the attitudes and perceived needs questionnaire.

The completed demographic data sheet can be found in Appendix E.

Procedure.---The surveyors utilized in this study were undergraduates from Loyola University and Mundelein College. They ranged in age from 18 to 21 years. Many were enrolled

in courses in either abnormal psychology or the psychology of personality and chose to take part in this survey as a term project.

Their training began with an orientation meeting wherein the project was explained to the student volunteers by community professionals, and some background of the Rogers Park Community was provided. In a second meeting the survey method used was explained and specific assignments were given. Teams of two people each were formed. This was done on the basis of partner preference, in order to provide male-female teams and to provide ease of transportation and mobility. Interview techniques and particularly role-playing of anticipated critical incidents were employed.

Interviewers were provided with suggestions regarding door-to-door interviewing and advised to proceed as follows: to request to see the head of the household, to identify oneself by name, university affiliation and by presenting one's identification card and to state one's purpose as follows:

We are conducting a research project to try to determine how many people of the Rogers Park-West Ridge Community feel about mental illness, and to determine what they think the community could use in the way of programs, facilities, and so forth to help people lead a happy, well-adjusted life and to help those people who have developed mental problems deal with these problems. This survey is a very important step in helping make this area a happier and more enjoyable place to live. Therefore, we would like you to help us with this survey by answering certain questions about mental illness and the community in general. We will not ask you any personal questions. Further, we will not report your name with your answers. Your answers will be kept secret to all but the members of the research team, so that there is no way that

your answers can be traced back to you, as an individual. Your cooperation is very important in making this survey a success, and we would appreciate it greatly if you would agree to cooperate. Would you be so kind as to help us out?

Students were advised to allow the community participants to look over the questionnaire in order to decide whether they wished to participate. Given that people claimed to have no time, questionnaires could be left and retrieved at a later date.

Surveyors were also requested to provide the community members with a questionnaire and to begin reading the initial instructions to him until assured that he was capable of handling the questionnaire himself. Surveyors could leave the questionnaire with the respondent for approximately the length of time required to complete it. Given that the respondent could not individually complete the form, the surveyors were advised to remain and assist.

Sampling.--The sampling technique utilized was a simple stratified block sampling method. The sampling procedure involved four phases. In phase one, the Rogers Park-West Ridge Area was divided into sub-zone areas by means of boundaries such as subway tracks, highways, etc., and by approximately equal numbers of precincts. Each of the 18 sub-zone areas contained between 13 and 48 blocks each individually numbered. Within each sub-zone area ten percent of the number of blocks were randomly sampled using the table of random numbers. Thus, for example, in sub-zone area B, consisting of 30 blocks, block B-6, B-11 and B-21 might be randomly selected.

In phase two, unit dwellings were defined. This was done as follows. At the second meeting of the surveyors each survey team was given several of the above randomly selected blocks. They were to determine the number of unit dwellings per block. A block was defined as that inside area bounded by four streets. A unit dwelling was defined as the number of families within a dwelling, as determined by the number of door bells or mail slots. Thus, an apartment building with 24 mail slots would contain 24 unit dwellings. Also included were transient hotels, homes for the aged, school residences, etc.

In the third phase the sampling units were determined. For each block randomly selected, the number of unit dwellings as discovered by the surveyors was totalled. Ten percent of the total number of unit dwellings per block were randomly selected. This ten percent constituted the sample to be surveyed. Thus, if block B-6 was found to have 200 unit dwellings, 20 were randomly selected to be surveyed. A cross sampling of each block provided extra addresses lest initially chosen family dwellings were either uncooperative or unable to complete the questionnaire.

In the fourth phase, the survey itself, survey teams were provided with a list of designated unit dwellings and with packets and were to begin the interviewing process. Each interview was estimated to require approximately 40 to 60 minutes and each survey team was given about 18 addresses or

unit dwellings to interview. The survey teams were given approximately one month within which to complete the total sampling.

CHAPTER III

RESULTS

This study addressed itself to three main areas of concern:

1. The relationship of perceived mental health need priority and selected demographic variables;
2. The relationship of perceived mental health need priority and selected demographic variables;
3. The relationship of the community's mental health attitudes and selected demographic variables.

The results obtained in each of these areas will be summarized individually.

Table 1 presents the means and standard deviations of the perceived mental health needs of the Rogers Park-West Ridge community. The average need score fell in the "strongly agree" to "agree" category for each age group, thus indicating that the average Rogers Park-West Ridge resident was in accordance with the establishment of services for their community. The community residents, in assuming that the needs within each of the age groupings were of approximately equal importance, indicated that no particular age bracket was estimated to be in greater need of services than any other.

Table 1

Means and Standard Deviations of the Perceived
Need Scores of the Rogers Park-West Ridge Community Using the
Need Survey Questionnaire

	<u>Mean</u>	<u>Standard Deviation</u>
Preschool Needs	1.7619*	.5131
Elementary School Needs	1.8636	.4961
Teenage Needs	1.8112	.5273
Young Adult Needs	1.9418	.5546
Middle-Aged Adult Needs	1.8630	.5352
Senior Citizen Needs	1.8316	.5210
Total of all Needs	1.8336	.5128

*A score of 1 means "strongly agree;" 2 means "agree"

Table 2 presents the means and standard deviations of the attitudes towards mental illness of the Rogers Park-West Ridge Community. The average Rogers Park-West Ridge citizen would appear to be a rather authoritarian individual who appears to believe that the mentally ill are an inferior class who should be handled via force. And because they are a threat to their environment they must be limited in action during and after release from the hospital. The average resident of this community presents himself as scoring lowest on the attitude scale on "Benevolence," and thus, in accordance with his scores on "Authoritarianism" and "Social Restrictiveness," neither encouraging, kind nor nurturant of the mentally ill.

Table 2

Means and Standard Deviations of Attitudes Toward Mental Illness of the Rogers Park-West Ridge Community, Using the "Opinions about Mental Illness Questionnaire:

<u>Factor</u>	<u>Mean</u>	<u>Standard Deviation</u>
Authoritarianism	53.5991	33.0921
Benevolence	16.1486	7.5236
Mental Health Ideology ,	19.0360	14.0670
Social Restrictiveness	33.9414	22.0558
Interpersonal Etiology	23.6306	13.9487

Table 3 includes the means and standard deviations of the demographic variables of the Rogers Park-West Ridge Community. It indicates that the average community respondent is American-born and likely to be employed in some responsible administrative white collar position. He is probably young to middle-aged. Educationally the average Rogers Park-West Ridge resident has had some college-level training and has lived in this community for a period of about two years and in the Chicago district for about five years.

Table 3

Means and Standard Deviations of the Demographic Variables of the Rogers Park-West Ridge Community

	<u>Mean</u>	<u>Standard Deviation</u>
Nationality	0.8919*	0.3112
Occupation	2.3108	0.8963
Age	1.5495	0.9049
Education	3.0000	1.2403
Rogers Park Residence	1.9820	1.1880
Chicago Residence	0.9054	0.3364

(*See Appendix F for definition of Demographic Variables)

Table 4 presents the relationship between the need and attitude variables. It indicates that there was a consistently small correlation between each of the attitude variables and each of the areas of needs. None of the 35 indices approached statistical significance at the .05 level.

Table 4

Relationship Between Attitudes Toward Mental Illness and the
Perceived Mental Health Needs of the Rogers Park-West Ridge Community

<u>Attitudes</u>	<u>Needs</u>						
	Preschool	Elem. School	Teens	Young Adult	Middle- Aged	Senior Citizen	Total of all Needs
Authoritarianism ²	0.0130	-0.0699	-0.031	-0.034	-0.026	-0.0327	-0.0196
Benevolence	0.0556	0.0006	0.0423	0.0386	0.0549	0.0469	0.0553
Mental Health Ideology	0.0882	0.0290	0.0526	0.0550	0.0609	0.0486	0.0632
Social Restrictiveness	-0.0138	-0.0733	-0.0357	-0.048	-0.0441	-0.0507	-0.0315
Interpersonal Etiology	0.0046	-0.0574	-0.0199	-0.0229	-0.0170	-0.0193	-0.0083

Included in Table 5 are the correlations between the perceived needs and the demographic variables of the Rogers Park-West Ridge Community. Table 5 indicates that the relationship between length of Rogers Park residence and the needs perceived to be characteristic of the elementary school-age level was significant at the .05 level. Thus, the longer one lived in this community the greater concern one had for the needs of children between the ages of 6 and 12 years. None of the remaining correlations were significant at the .05 level.

The correlations between the attitudes toward mental illness and the demographic variables of the Rogers Park-West Ridge Community are presented in Table 6. Significance at the .05 level was obtained for correlations between "authoritarianism" and education, indicating that the more educated a resident is, the more likely he is to be rigid and punitive in regard to the mentally ill. As well, significance was obtained between the attitude measures of "Benevolence," "Social Restrictiveness" and "Interpersonal Etiology" and the demographic variable, education. The relationship was in a positive direction such that the higher education a Rogers Park-West Ridge resident has, the greater is the likelihood that he will rank high on these attitude measures.

The negative correlations between these same attitude measures ("Authoritarianism, Benevolence, Social Restrictiveness, and Interpersonal Etiology") and length of Rogers Park-

Table 5

Relationship of Demographic Variables and Perceived
Mental Health Needs of the Rogers Park-West Ridge Community

	<u>Needs</u>						
	Preschool	Elem. School	Teens	Young Adult	Middle- Aged	Senior Citizen	Total of All Needs
Nationality	-0.0283	-0.0957	-0.1183	-0.1165	-0.1311	-0.1285	-0.0935
Occupation	0.0225	0.0108	0.0517	0.0583	0.0655	0.0732	0.0499
Age	-0.0510	-0.0487	-0.0487	-0.0465	-0.0333	-0.0380	-0.0456
Education	-0.0030	-0.0204	0.0204	0.0260	0.0330	0.0372	0.0249
Rogers Park Residence	-0.0368	0.2056*	-0.0935	-0.0583	0.0621	0.0748	-0.0667
Chicago Residence	0.0899	0.1183	0.0172	0.0371	0.0135	-0.0090	0.0330

*p = .05

Table 6

Relationship Between Attitudes Toward Mental Illness
 And Demographic Variables of the Rogers Park-West Ridge Community

	<u>Demographic Variables</u>					
	Nationality	Occupation	Age	Education	Rogers Park Residence	Chicago Residence
Authoritarianism	-0.1026	0.0983	0.1224	0.1952*	-0.1438*	-0.0055
Benevolence	-0.1187	0.1152	-0.0945	0.1746*	-0.1500*	-0.0194
Mental Health Ideology	-0.1645*	0.0562	-0.0400	0.1087	-0.0833	0.0265
Social Restrictiveness	-0.1024	0.0755	-0.1253	0.1558*	-0.1416*	0.0114
Interpersonal Etiology	-0.1291	0.0722	-0.1047	0.1363*	-0.1394*	0.0191

*p = .05

34

West Ridge residence were significant at the .05 level. This appears to indicate that the longer one resided in this community the less likely one was to be strongly characterized by any one of these attitude measures.

The negative correlation between mental health ideology and nationality, significant at the .05 level, indicates that foreign-born residents of the Rogers Park-West Ridge Community were likely to be staunch in their belief that "mental patients are much like normal people, differing in degree but not in kind."

CHAPTER IV

DISCUSSION

It appears that the implementation of community mental health services within the Rogers Park-West Ridge Community would be met with by a rather passive disinterested response on the part of the residents. They would in all probability not resist the initiation of such services, nor would they be strongly in support. Their general reaction might be characterized as one of apathy. In part this might be due to the fact that the younger, better-educated residents of the Rogers Park-West Ridge Community are essentially transient in nature. Thus, although they hold lip service to the theoretical implementation of community mental health services in fact they hold less positive attitudes to the actual initiation of such services within their immediate living area. Their lack of permanence in residence within this area appears to contribute to their feelings of unconcern and disinvolvement in the mental health of this community.

Interestingly, as one continues residence in the Rogers Park-West Ridge Community it appears that one becomes more positive in attitude to the mentally ill. Such individuals, however, although more supportive of community mental health endeavors tend to be in a less likely position, educationally and motivationally, to put community mental health plans into effect. Younger and better-educated residents are usually

both knowledgeable and capable of implementing change in the area of community mental health but as previously stated, they are transient in nature. The older residents have less knowledge of channels wherein such changes can be made. As well, longer residence in Rogers Park appears to coincide with family life. Interest in community mental health concerns may thus increase for longer residents, but time and energy available to such may be usurped by family concerns, thus making involvement in social concerns unlikely.

As well, there appears to exist in this community what might be characterized as a middle-class rigidity. The average Rogers Park-West Ridge resident is a white collar worker. He is thus employed in a clerical-business type of occupation. According to the demands of his employment he might be characterized by a degree of objectivity and resistance to liberal social change in the provision of community mental health needs to the general population. Past proposals, as well, to create half-way houses for former mental hospital patients in the Rogers Park-West Ridge district aroused strong negative reactions and concern that "undesireable" types of individuals would be drawn into the district. The surveyed conservatism and lack of enthusiasm to community mental health possibilities might thus be a remnant of this over-reaction and a defensive reaction to change, similar to that described by Klein (1968).

This study appears somewhat disappointing in its failure to provide a more clear-cut picture of the Rogers Park-West

Ridge resident, his attitudes toward mental illness, his perception of mental health needs and the interrelationships of all these. One has a general picture of the average Rogers Park-West Ridge citizen as an American-born individual of about 28 years of age who has some college level training and is employed in a clerical type of job. He has resided in this community for about two years and in the Chicago district for about five years. This individual appears to perceive a general undifferentiated need for most mental health services and does not discriminate between services pertinent to particular ages. His perception of the need for such services is not a reflection of his motivation to initiate such. This average resident appears attitudinally rigid, restrictive and authoritarian in relation to the mentally ill. The fact that his attitudes are unrelated to his perception of mental health needs would seem to indicate that to some extent he dichotomizes mental illness and mental health.

It appears that the longer one lives in the Rogers Park-West Ridge Community that the more one becomes concerned with the needs pertinent to the elementary school-aged. This brings to mind Klein's statement that programs under mental health auspices are largely supported by the upper-middle class young families with children (1968). It might also indicate the group from whom support within this community might be sought for mental health endeavours.

Several factors might have contributed to the lack of differentiation within this study. It seems that the needs

questionnaire did not adequately differentiate between one's perception of the importance of needs relative to certain age periods. All needs were assessed to be of approximately equal value by all residents. This may have arisen because the needs questionnaire itself did not provide a sufficiently fine discrimination between age periods. Many needs could have belonged to several age periods. As well, the tendency on the part of the residents to answer in a positive direction may have been due to the uni-directionality of the ratings of the needs and to a response set on the part of individuals to appear in a positive light.

Within the survey method itself several areas of possible bias exist. Each respondent was given the choice of completing the demographic data questionnaire. However, only those forms in which all three sections (attitude, need and demographic variables) were completed were used in assessing the results. Individuals who completed the demographic section might be differentiated from those who refused on such traits as social compliance, social concern, etc. The exclusion of residents who refused to complete this section by the provision of a choice may have eliminated from the results those individuals less conforming in response. A comparison of the attitude and needs questionnaire of those individuals who did and those who did not complete the demographic data sheet might provide a more accurate picture of this community's attitudes and need perception.

Many surveyors or experimenters were utilized in this study with various sets toward surveying the community. The variability in motivation, manner of presentation of the survey to the residents and seriousness in the performance of the assigned tasks may have affected the responses of the residents. The wide variety of surveyors and the large number also eliminated any possibility of a comparison on the part of the surveyors of the motivation and the test taking attitude of a respondent in completing the questionnaire.

The long range goal of this study was to assess the Rogers Park-West Ridge Community with a view to the creation of a community mental health center. It would seem that in the light of the apathy of the residents found in this survey that a community-wide education program could be initiated whereby people are acquainted with the benefits provided by community mental health endeavours and their negative set toward mental illness somewhat neutralized, via knowledge about the mentally ill.

CHAPTER V

SUMMARY

This study was undertaken to assess the Rogers Park-West Community with regard to the creation of community mental health centers. The following three issues were examined:

1. The relationship of perceived mental health needs and prevailing mental health attitudes
2. The relationship of perceived mental health needs priority and selected demographic variables
3. The relationship of the community's mental health attitudes and selected demographic variables.

A simple stratified block sampling was used in the survey of the community and about 300 homes were randomly selected from this sampling. A questionnaire assessing attitudes toward mental illness, perceived needs and selected demographic variables, such as age, education, occupation, length of residence, etc. was distributed by undergraduate college students. Results were correlated.

The results indicated that community mental health services in the Rogers Park-West Ridge Community would be responded to somewhat apathetically, with neither resistance nor enthusiasm. With continued residence it appears that one becomes more positive in attitude to the mentally ill and more concerned with needs pertinent to the elementary school-aged. The average Rogers Park-West Ridge resident is American-born, about 28 years of age, with some college level training. He is employed in a clerical type of job, has lived in this

community for about 2 years and in the Chicago district for about 5 years. He appears rigid, authoritarian and somewhat restrictive of the mentally ill.

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Appendix A -- The Attitude Survey Questionnaire (Opinions
about Mental Illness Questionnaire)

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

strongly agree agree not sure disagree strongly disagree
(1) (2) (3) (4) (5)

Please circle the number beside each statement which comes closest to saying how you feel about each statement. There are no right or wrong answers. We are interested only in your opinion. It is very important that you answer every item.

	strongly agree	agree	not sure	disagree	strongly disagree
1. Nervous breakdowns usually result when people work too hard.	1	2	3	4	5
2. Mental illness is an illness like any other.	1	2	3	4	5
3. Most patients in mental hospitals are not dangerous.	1	2	3	4	5
4. Although patients discharged from mental hospitals may seem alright, they should not be allowed to marry.	1	2	3	4	5
5. If parents loved their children more, there would be less mental illness.	1	2	3	4	5
6. It is easy to recognize someone who had a serious mental illness.	1	2	3	4	5

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|---|---|---|---|---|---|
| 7. People who are mentally ill let their emotions control them; normal people think things out. | 1 | 2 | 3 | 4 | 5 |
| 8. People who were once patients in mental hospitals are no more dangerous than the average citizen. | 1 | 2 | 3 | 4 | 5 |
| 9. When a person has a problem or a worry, it is best not to think about it, but keep busy with more pleasant things. | 1 | 2 | 3 | 4 | 5 |
| 10. Although they usually aren't aware of it, many people become mentally ill to avoid the difficult problems of everyday life. | 1 | 2 | 3 | 4 | 5 |
| 11. There is something about mental patients that makes it easy to tell them from normal people. | 1 | 2 | 3 | 4 | 5 |
| 12. Even though patients in mental hospitals behave in funny ways, it is wrong to laugh about them. | 1 | 2 | 3 | 4 | 5 |
| 13. Most mental patients are willing to work. | 1 | 2 | 3 | 4 | 5 |
| 14. The small children of patients in mental hospitals should not be allowed to visit them. | 1 | 2 | 3 | 4 | 5 |
| 15. People who are successful in their work seldom become mentally ill. | 1 | 2 | 3 | 4 | 5 |
| 16. People would not become mentally ill if they avoided bad thoughts. | 1 | 2 | 3 | 4 | 5 |
| 17. Patients in mental hospitals are in many ways like children. | 1 | 2 | 3 | 4 | 5 |
| 18. More tax money should be spent in the care and treatment of people with severe mental illness. | 1 | 2 | 3 | 4 | 5 |
| 19. A heart patient has just one thing wrong with him, while a mentally ill person is completely different from other patients. | 1 | 2 | 3 | 4 | 5 |

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| 20. Mental patients come from homes where the parents took little interest in their children. | 1 | 2 | 3 | 4 | 5 |
| 21. People with mental illness should never be treated in the same hospital as people with physical illness. | 1 | 2 | 3 | 4 | 5 |
| 22. Anyone who tries hard to better himself deserves the respect of others. | 1 | 2 | 3 | 4 | 5 |
| 23. If our hospitals had enough well-trained doctors, nurses and aides many of the patients would get well enough to live outside the hospital. | 1 | 2 | 3 | 4 | 5 |
| 24. A woman would be foolish to marry a man who has had a severe mental illness, even though he seems fully recovered. | 1 | 2 | 3 | 4 | 5 |
| 25. If the children of mentally ill parents were raised by normal parents, they would probably not become mentally ill. | 1 | 2 | 3 | 4 | 5 |
| 26. People who have been patients in a mental hospital will never be their old selves again. | 1 | 2 | 3 | 4 | 5 |
| 27. Many mental patients are capable of skilled labor, even though in some ways they are very disturbed mentally. | 1 | 2 | 3 | 4 | 5 |
| 28. Our mental hospitals seem more like prisons than like places where mentally ill people can be cared for. | 1 | 2 | 3 | 4 | 5 |
| 29. Anyone who is in a hospital for a mental illness should not be allowed to vote. | 1 | 2 | 3 | 4 | 5 |
| 30. The mental illness of many people is caused by the separation or divorce of their parents during childhood. | 1 | 2 | 3 | 4 | 5 |

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|--|---|---|---|---|---|
| 31. The best way to handle patients in mental hospitals is to keep them behind locked doors. | 1 | 2 | 3 | 4 | 5 |
| 32. To become a patient in a mental hospital is to become a failure in life. | 1 | 2 | 3 | 4 | 5 |
| 33. The patients of mental hospitals should be allowed more privacy. | 1 | 2 | 3 | 4 | 5 |
| 34. If a patient in a mental hospital attacks someone, he should be punished so he doesn't do it again. | 1 | 2 | 3 | 4 | 5 |
| 35. If the children of normal parents were raised by mentally ill parents they would probably become mentally ill. | 1 | 2 | 3 | 4 | 5 |
| 36. Every mental hospital should be surrounded by a high fence and guards. | 1 | 2 | 3 | 4 | 5 |
| 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. | 1 | 2 | 3 | 4 | 5 |
| 38. People (both veterans and non-veterans) who are unable to work because of mental illness should receive money for living expenses. | 1 | 2 | 3 | 4 | 5 |
| 39. Mental illness is usually caused by some disease of the nervous system. | 1 | 2 | 3 | 4 | 5 |
| 40. Regardless of how you look at it, patients with severe mental illness are no longer really human. | 1 | 2 | 3 | 4 | 5 |
| 41. Most patients in mental hospitals don't care how they look. | 1 | 2 | 3 | 4 | 5 |
| 42. Most women who were once patients in a mental hospital could be trusted as baby sitters. | 1 | 2 | 3 | 4 | 5 |

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|---|---|---|---|---|---|
| 43. College professors are more likely to become mentally ill than are business men. | 1 | 2 | 3 | 4 | 5 |
| 44. Many people who have never been patients in a mental hospital are more mentally ill than many hospitalized mental patients. | 1 | 2 | 3 | 4 | 5 |
| 45. Although some mental patients seem alright, it is dangerous to forget for a moment that they are mentally ill. | 1 | 2 | 3 | 4 | 5 |
| 46. Sometimes mental illness is punishment for bad deeds. | 1 | 2 | 3 | 4 | 5 |
| 47. Our mental hospitals should be organized in a way that makes the patients feel as much as possible like he is living at home. | 1 | 2 | 3 | 4 | 5 |
| 48. One of the main causes of mental illness is a lack of moral strength or will power. | 1 | 2 | 3 | 4 | 5 |
| 49. There is little that can be done for patients in a mental hospital except to see that they are comfortable and well fed. | 1 | 2 | 3 | 4 | 5 |
| 50. Many mental patients would remain in the hospital until they were well, even if the doors were unlocked. | 1 | 2 | 3 | 4 | 5 |
| 51. All patients in mental hospitals should be prevented from having children by a painless operation. | 1 | 2 | 3 | 4 | 5 |

Please check back and make sure that you have not left out any statements or pages of statements.

Appendix B -- The Needs Survey Questionnaire

Every individual in a community has problems of some sort, and everyone in a community is entitled to and needs help in dealing with these problems. The following statements concern services which could be made available within a community to assist people with their problems. We are interested in what you consider important for better living within your community, that is, what you might benefit from or what you feel your immediate neighborhood might benefit from.

DIRECTIONS: Indicate your opinions about each of the following statements and estimate its need within your community by circling the appropriate number under each statement. Be sure to circle each statement.

	Strongly Agree	Agree	Indif-ferent	Disa-gree	Strongly Disagree
1. Pre-natal classes for pregnant mothers and interested fathers.	1	2	3	4	5
2. Dinner delivery service for the sick and the elderly who are bed-ridden.	1	2	3	4	5
3. A community youth program for teens.	1	2	3	4	5
4. An emergency alert service for quick help with such as suicide threats, accidents or any unexpected problems.	1	2	3	4	5
5. A job information and placement service.	1	2	3	4	5
6. Services for the emotionally disturbed in a local general hospital.	1	2	3	4	5
7. Day hospitals for the mentally ill who remain in the home.	1	2	3	4	5
8. Visiting nurses made available, especially for new mothers and for the aged.	1	2	3	4	5
9. A community boys club for boys between seven and thirteen years.	1	2	3	4	5

10.	Help for the alcoholic and his family	1	2	3	4	5
11.	Help for parents of young run-aways.	1	2	3	4	5
12.	Well-baby clinics to which mothers might bring children for inoculations yearly check-ups, various sicknesses and medical emergencies.	1	2	3	4	5
13.	A tutoring center for children with poor grades or with special difficulties in school, or for children with special types of learning disabilities.	1	2	3	4	5
14.	Programs and activities for senior citizens.	1	2	3	4	5
15.	Pre-marital counselling services.	1	2	3	4	5
16.	Half-way houses for people just out of the hospital but not yet ready to return to the community.	1	2	3	4	5
17.	Talks for teachers and parents about the different emotional problems of children, what they are, how you recognize them and what you do when they are evident.	1	2	3	4	5
18.	An "off street club" for adolescent gangs.	1	2	3	4	5
19.	Some type of companionship program for the elderly.	1	2	3	4	5
20.	After-care for those with emotional problems who have returned to live with their families.	1	2	3	4	5
21.	A telephone information service where one might learn where to go and whom to see when problems arise.	1	2	3	4	5
22.	Nursery schools for preschool children.	1	2	3	4	5
23.	A counselling service for adolescents with problems.	1	2	3	4	5

- | | | | | | |
|--|---|---|---|---|---|
| 24. A number one might call when things get rough. | 1 | 2 | 3 | 4 | 5 |
| 25. Day-care centers for the children of working mothers. | 1 | 2 | 3 | 4 | 5 |
| 26. Professional information resources for parents and teachers about alcohol and drugs and their use by adolescents. | 1 | 2 | 3 | 4 | 5 |
| 27. Walk-in, side-walk or trouble-shooting clinics in your neighborhood, to which you might bring difficulties which could vary from getting help with budgeting to patching up quarrels, to receiving psychological help. | 1 | 2 | 3 | 4 | 5 |
| 28. Counseling for families with serious difficulties. | 1 | 2 | 3 | 4 | 5 |
| 29. Some type of guidance and information exchange for the parents of kindergarten and primary school children. | 1 | 2 | 3 | 4 | 5 |
| 30. Neighborhood rehabilitation services where one can receive help in getting back into the swing. | 1 | 2 | 3 | 4 | 5 |
| 31. A place where teen-age drug users can go for help. | 1 | 2 | 3 | 4 | 5 |
| 32. Marital adjustment clinics where one might get counselling for stormy marriages. | 1 | 2 | 3 | 4 | 5 |
| 33. A clinic for children with emotional problems. | 1 | 2 | 3 | 4 | 5 |
| 34. A community center where many of the above might be localized. | 1 | 2 | 3 | 4 | 5 |

List any other services you or your neighborhood might benefit from which are not included in the above.

35. _____
36. _____

Appendix C -- Mental Health Needs Survey (per age group)

Generally speaking, what do you think are the most serious problems in your area for:

- A. Preschool Children
- B. Elementary School Children
- C. Teenages
- D. Young Adults
- E. The Middle-Aged
- F. Senior Citizens

Appendix E -- The Demographic Data Sheet

Interviewer: _____ Block Number: _____

If you do not want to answer some of the following questions, please feel free to just skip those questions.

1. Where were you born? _____
2. How long have you lived in this neighborhood? _____
3. How long have you lived in the Chicago area? _____
4. How old are you? _____
5. Marital status (check one) Married ___ Single ___ Divorced ___
Separated ___ Widowed ___
6. Number of children and ages: _____
7. What was the last grade year completed in school? _____
8. What is the occupation of the head of the household? _____
9. What do you see as the function of a Community Mental Health Center in your area?

10. How would you feel about the introduction of a Community Mental Health Center into your neighborhood? Would you please explain why you feel the way you do.

Appendix F -- Definition of the Demographic Variables
(for computer)

I Sex: 0 - Male
1 - Female

II Nationality: 0 - Foreign-Born
1 - American-Born

III Occupation: according to Hollingshed and Redlich (1958)

- 0 - unskilled or semi-skilled labor, for tasks involving no training or a very small amount of training, for example, janitor or assembly line worker.
- 1 - skilled laborer, employed in manual activity which requires training and experience, for example, machinist or self-employed farmer.
- 2 - lower white collar, involved in a small business or in clerical or similar work which is not primarily manual and/or which depends on some educational or special background, for example, policeman, sales clerk, or typist.
- 3 - upper white collar, employed in more responsible administrative white collar positions, for example, supervisor, large scale farmer, school teacher, nurse.
- 4 - professional or executive, whose employment depends on professional training beyond the college level or important executive responsibility or high financial status, for example, university professor, attorney, engineer.
- 5 - retired or unemployed or on ADC
- 6 - student

IV Age: (based on the fact that surveyor judged the individual to be of sufficient maturity to adequately answer the Questionnaire)

- 0 - Adolescent: 13 to 21 years
- 1 - Young Adult: 22 to 35 years
- 2 - Middle-Aged Adult: 36 to 54 years
- 3 - Senior Citizen: 55 years and up

V Education: 0 - 8th grade or less
1 - some high school
2 - high school graduate
3 - some college
4 - college graduate
5 - B.A. plus further professional training

VI Length of Residence in Rogers Park: 0 - less than 5 years
1 - 5 years and above

VII length of Residence in the Chicago District:

0 - less than 5 years
1 - 5 years and above

APPROVAL SHEET

The thesis submitted by Barbara J. Dydyk has been read and approved by members of the Department of Psychology.

The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Philosophy.

9-9-71

Date

J. E. R. Shack

Signature of Advisor