

RETIREEES' ATTITUDES TOWARD MENTAL ILLNESS TREATMENT: A LIFE-
COURSE PERSPECTIVE

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This purpose of this dissertation was to examine the attitudes of retirees toward mental illness treatment. Secondary data from the Survey Research Center at the University of North Texas was utilized for this study. The focus was on the influence that gender, income, education, race/ethnicity, personal experience, fear, goodwill, and social control might have had on retirees' attitudes toward mental illness treatment. An $n = 225$ was selected out of the existing data to serve as the sample population. Binary logistic regression was utilized to analyze the data. Results indicated that the obtained significant findings were consistent with existing literature.

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I would like to thank my committee for their tireless efforts and support during this process and for providing me the guidance and direction needed to complete this research study. I offer special thanks to the Survey Research Center and the City of Fort Worth, Texas' Health Department for allowing me to utilize their data for this study.

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CHAPTER 1

INTRODUCTION TO THE STUDY

The concept of mental illness treatment stirs a variety of emotions and attitudes in many people. These attitudes were the focus of this study. The attitudes that some have are influenced by a collective set of events, circumstances, and experiences that occur over the life-span. This study focused on variables that can influence a person's attitude about mental illness treatment. People experience a broad spectrum of circumstances during their life-span, and mental illness is one that tends to frighten people. Perhaps one of the reasons that mental illness frightens people is because of the stigma associated with it, which leads to a further misunderstanding of mental illness. Moreover, people who are reluctant to access proper mental illness treatment may have a negative attitude about treatment (Gerhart, 1990). It was this very issue which was the focus of this research study: What kind of attitudes did today's cohort of retirees express as such pertained to mental illness treatment?

Examining what variables played a role in shaping and influencing retirees' attitudes about mental illness treatment was instrumental in understanding how to change the way mental illness treatment is perceived. The attitude a person expresses about mental illness treatment can shift from positive to negative at any given time during their life. Understanding what variables can facilitate a change in attitude is important. Being that this study used secondary data from a prior study completed by the Survey Research Center (SRC) of the University of North Texas (UNT), the variables examined were predetermined. The UNT SRC conceptualized attitudes toward mental illness as encompassing general attitudes toward mental health and

people with mental illness, treatment of mental illness, the identification of mental illness and their experience with mental illness (Ver Duin, Ruggiere, & Glass, 2004).

Research Statement

The primary research question answered in this study was do retirees have a negative or positive view of mental illness. Secondly, this study examined if any of the differences could be explained by the life-course perspective: (1) ethnicity, (2) years of education, (3) gender, (4) personal experience, and (5) income.

Purpose of the Study

The purpose of this study was to examine the attitudes toward mental illness of retirees living in Tarrant County, Texas. Determining what influences retirees' attitudes is important in guiding future mental health policy and practice.

Rationale for the Study

The rationale for the study was to examine the way that attitudes of retirees impact their views on mental illness and mental health services. Little research has been conducted in the United States on the attitudes of the elderly toward mental illness and mental health services. The majority of the research conducted in the United States is dated, and new analysis needed further exploration. This study has helped to lay the foundation for future research, policy needs, and service development.

Theoretical Foundation

The foundation for this study was life-course theory, as described by Binstock and George (2006), which defines life-course perspective as the total life experiences and roles of a single person or cohort of people over a period of time and attempting to account for both the immediate and future impacts of the resulting actions. When

looking at retirees, several life experiences could affect them as a whole. For example, retirees grew up during a unique period in American history and their experiences shaped not only each individual but also the cohort. These life experiences shaped the actions and attitudes of individuals in the cohort, making it distinct from cohorts growing up in different historical times. This concept is referred to as historical time, more specifically, the period effect (Binstock & George). The life-course perspective has several key concepts that can be part of explaining retirees' attitudes, expectations, and usage of mental health services.

Concepts of Life-course Perspective

In discussing the life-course perspective, several major concepts must be addressed: trajectories, transitions, turning points, cultural influences, timing in lives, linked lives, and adaptive strategies. Each of these are discussed here in regard to how the concept influences retirees and their attitudes, expectations, and usage of the mental health system, as well as how the concept affects their attitudes, expectations, and usage of the mental health system.

Trajectories are defined as patterns and tasks assumed by individuals during their life and are essential in understanding their decisions and experiences in later life (Willis & Reid, 1999). Trajectories tend to be long lasting patterns of behavior over the course of the life-span. For defining moments in individuals' lives, trajectories are important to look at and can consist of adulthood, parenthood, and career paths. One of the most significant trajectories the retirees would have experienced is that of adulthood. Adulthood would have been when they turned into adults and started making life choices for themselves. The ease of the transition to adulthood from childhood could

significantly influence the future attitudes of retirees. Depending upon what type of experiences retirees may have had, their life trajectories could significantly impact the attitudes toward mental health services in later life.

Moen, Elder, and Luscher (2001) describe transition as “the different roles that people experience throughout their life-span; from home to school, from school to work, from singlehood to widowhood-these transitions offer a framework for analyzing the life-course” (p. 368). Transitions are specific life events that influence the life-course of individuals or cohorts and are closely related to trajectories. When discussing retirees, many experienced the transition from home to college. For many this was the first experience beyond their own upbringing. This transition could have had a tremendous impact on beliefs learned while living with their parents.

Turning points are defined as life changing events that occur during individual’s lives than can alter the course of life (Moen et al., 2001). Having a prior experience with mental illness, either personally or with a family member or close friend could represent a turning point. This would be especially true if the experience was negative.

Cultural influences can be explained as values and beliefs that impact how people age and shape their actions or in-actions upon the environment in which they live (Minkler & Estes, 1999). Culture can be grouped into several categories that include ethnic culture, religious culture, national culture, and even regional culture. Any of these cultural categories could have had an impression on retirees and the way that they view mental illness. Depending upon which part of the country retirees live, they could be exposed to different cultural attitudes and beliefs.

Timing in life is defined by Moen et al. (2001) as:

Historical location or time, the social timing of transitions across the life-course, the synchrony of individual careers and the lives of significant others, and the one's life stage at the point of social change. The timing of an event may be more consequential than its occurrence. (p. 114)

One of the biggest examples of this concept could be the impact of deinstitutionalization on many retirees. Deinstitutionalization occurred in the 1960s when many of today's retirees were beginning to shape their attitudes and beliefs.

Social timing could have an impact on the attitudes of baby boomers toward mental health services. Moen et al. (2001) define social timing as, "the incidence, duration, and sequence of roles related to age expectations and beliefs" (p. 114). Depending upon the environment in which retirees were raised, their attitudes could be shaped by changes in their families.

According to Moen et al. (2001), the term linked lives is the interaction of an individual's environment and peer groups over the course of one's life. The development of new relationships can influence people's attitudes and beliefs. For retirees, this means as they age, people leave and enter their lives, thus having an impact on their attitudes.

Adaptive strategies can be best looked at as understanding why certain people develop positive coping skills and other fail to and requires knowledge of the internal desire and resources of the individual, the social support received, and the circumstances surrounding the events or situation (Elder, 1999). Having a good support system and positive role models throughout life can assist in creating the ability to cope with life's challenges. For a retiree who has demonstrated the ability to cope

appropriately with life's stressors, this coping ability can influence attitudes toward mental illness treatment. Looking at this specific cohort of retirees is how the life-course perspective will be applied in this study.

Operationalizing Concepts and Terms

The following concepts and terms were operationalized for the purpose of this study.

Attitude. The personal belief or way of feeling about mental illness. This belief can be influenced by the personal experiences of the individual over the course of a lifetime.

Fear. A negative attitude or belief about mental illness that perpetuates a stigma in society and creates a sense of trepidation around those who suffer from mental illness. This fear can be the result of negative experiences over the course of one's life or the societal perception of mental illness in which one was raised.

Goodwill. The belief that those with mental illness deserve respect and dignity. This can be the result of positive experiences with those with mental illness over the course of a lifetime. Goodwill can result from either personal experience or by generational influences.

Mental illness. Any diagnosis contained in the American Psychological Association's (2000). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition: Text Revision* (DSM-IV-TR).

Personal experience. Prior interaction with the mental health system as a result of personal, family, or friend circumstance. This experience could be either positive or negative, helping to shape current attitudes toward mental illness treatment.

Retiree. A person who is no longer in the workforce by choice and is considered to be a sample of the cohort for this study.

Social control. The belief that society should control, influence, or limit the abilities of those suffering from mental illness. Social control ensures society is kept safe from those suffering from mental illness and could be the result of the manner in which the mentally ill were treated during the course of the life-span.

Treatment. A medically approved and recognized form of intervention to control, mitigate, or alleviate a mental illness and includes but is not limited to medication and therapy.

Limitations

The following list represented the limitations of the research study:

1. No specific age variable was part of the research data.
2. People might not have provided accurate information.
3. Data were limited to only people living in Tarrant County.
4. Data were limited to only those people with telephones, could have left out many possible respondents.
5. Using secondary data limited the ability to expand questions.
6. Ability to conduct follow up questions was not possible due to nature of the data.

Summary

The life-course perspective is a valuable tool when examining the impact of a person's history (external and personal) on developing their attitudes toward mental illness. Since the focus of this study was the attitudes of retirees toward mental health

treatment, use of the life-course perspective was a logical choice. Retirees have seen a great deal of change in societal attitudes toward mental health, and how it can be treated. By using culture, education, gender, age and income and their effects on attitudes toward mental health treatment, the life-course perspective was applied in this study.

Being that the elderly are one of the most vulnerable populations and at risk for a variety of diseases and illness, mental illness often is prioritized near the bottom for services provided to the elderly. This study aimed to shed some light on the attitudes of retirees and the possible implications that those attitudes could have for many of the retirees in need of treatment.

CHAPTER 2

REVIEW OF THE LITERATURE

Measuring Attitudes Toward Mental Illness

An exhaustive review of the literature regarding attitudes toward mental illness and life-course perspective was conducted. Unfortunately limited research was available in the United States pertaining to attitudes toward mental illness. The majority of the research literature comes from outside the country. Regardless of this, sufficient data on attitudes toward mental illness was found for this review. It is important for health care practitioners, public policy makers, and the general public at large to understand how attitudes play into those with mental illness accessing appropriate treatment. Link, Phelan, Bresnahan, Stueve, and Pescosolido (1999) echo this as they report, “the history of social psychiatry teaches us that cultural conceptions of mental illness have dramatic consequences for help seeking, stereotyping, and the kinds of treatment structures we create for people with mental illness” (p. 1328).

In order to best measure the attitudes of society at large, a method of using vignettes was developed. Jorm, Korten, Jacomb, Christensen, and Henderson (1999) used such vignettes, and in the study, each participant was read a vignette describing an individual with a particular mental illness and then asked a variety of questions. Angermeyer and Matschinger (1999) utilized vignettes to describe symptoms of a mental illness without diagnosing it. The participants were then subject to structured interviews in which they answered questions regarding the vignette.

Life-Course Perspective

There are a multitude of variables that have impacted the way that many retirees may view mental illness. Link et al. (1999) recognizes a multitude of cultural factors play an important role in creating attitudes toward those with mental illness, and this is the basis of life-course perspective. Cultural factors that influence people's attitudes can change over the course of the life-span. Glendinning, Buchanan, and Rose (2002) with the Scottish Executive Social Research Committee report, "those over age 75 had a more negative view of people with mental illness than those 74 and under" (p. 3). Currin, Hayslip, Schneider, and Kooken (1998) report that cultural history plays a large role in the development of attitudes by the elderly. For instance, Currin et al. find that increases in positive attitudes were related to the increase in society's positive attitudes toward mental health. This is in line with the life-course concept of cultural influences. Being that the elderly were raised in a different cultural environment than middle-aged adults of today, the elderly may have different views of mental illness as a cohort than others in society. Givens et al. (2006) discuss how life experiences from the past have a tendency to sway the elderly when it comes to being treated with anti-depressant medications.

In the education and training of health-care professionals, a life-course approach offers the potential to enhance the integration of teaching and to prepare students, across both the developed and developing worlds, for carrying out their responsibilities in the twenty-first century. (World Health Organization, n.d., p. 3)

According to the World Health Organization:

A life-course approach emphasizes a temporal and social perspective, looking back across an individual's or a cohort's life experiences or across generations for clues to current pattern of health and disease, whilst recognizing that both past and present experiences are shaped by the wider social, economic and cultural context. (p. 4)

This demonstrates that the life-course perspective is ideal for examining the attitudes of retirees toward mental illness.

Treatment

Utilization of mental health services for treatment of a mental illness has a large part to do with attitudes. Not only do attitudes affect a person's willingness to seek treatment, but attitudes influence what type of treatment they will accept. Leaf, Bruce, Tischler, and Holzer (1987) report that a large number of people had favorable attitudes toward mental health treatment but failed to utilize the services due to fear that others might find out about them receiving assistance. This circumstance is especially true for the elderly population.

Another relevant factor is the reluctance of elderly patients to maintain compliance with anti-depressant medication. This problem, according to Givens et al. (2006), is due to the fact that many elderly individuals fear becoming addicted to psychotropic medications. This fear is an attitude generated by generational stigmas from older anti-depressants (Givens et al., 2006).

Personal Experience

As pointed out when discussing the life-course theory, personal experience (turning points) can have a dramatic impact shaping people's attitudes toward mental

health services. Jang, Kim, Hansen, and Chiriboga (2007) point out that those who have had prior exposure to mental health treatment tend to express more accepting beliefs. This could be an outcome of more education and knowledge about mental health services as a result personal experience. Van Voorhees et al. (2003) report that individuals receiving treatment from a general practitioner exhibit more negative attitudes toward mental health treatment than those who receive treatment from a mental health professional. This deferential attitude supports the proposition that individuals who have a prior experience with mental health services have more accepting attitudes toward mental health treatment. People with prior negative experiences will likely harbor poor attitudes toward mental health treatment in the future (Givens et al., 2006). This finding could be related to elderly patients refusing to take anti-depressant medications as a result of negative experiences with older medications.

Gender

Leaf et al. (1987) report that men have a greater belief that their families would become angry with them for receiving mental health treatment than do women. They find that women are more open to mental health services than men. On other attitudinal factors, men and women have similar beliefs. According to Leaf et al. (1987), some of the attitudes that men and women have in common are openness to services, impediments to treatment, religious assistance with mental health problems, and primary care physician help with mental health problems.

Women utilize mental health services more frequently than do their male counterparts according to Diala et al. (2000). This finding was consistent with a study conducted by Dobalian and Rivers (2008) who find that women tend to use mental

health services more than men. One unique disparity relates to men suffering from depression and being on Medicaid who tend to use mental health services more than women suffering from depression (Dobalian & Rivers).

Goodwill

According to Wolff, Pathare, Craig, and Leff (1996), goodwill is described as having a more accepting attitude toward those individuals with mental illness, often believing that support, treatment, and inclusion are the most appropriate ways to engage the mentally ill. Those who show goodwill tend to tolerate and support services for the mentally ill. Individuals that show a clear understanding of mental illness tend to have more goodwill than those who do not demonstrate a clear understanding of mental illness (Wolff et al.). Individuals who are not highly educated often have less goodwill than others (Wolff et al.). Individuals with more positive attitudes toward the mentally ill show more goodwill than those who have negative attitudes toward the mentally ill (Wolff et al.).

Education

Diala et al. (2000) report that the more education people have, the more likely they are to use mental health services. Leaf et al. (1987) report those individuals with lower levels of education often forgo mental health treatment. This lack of utilization can be attributed to economic limitations, stigma, and uninformed about mental health issues. Dobalian and Rivers (2008) conclude the more education a person has the more likely they are to utilize mental health services.

Steele, Dewa, and Lee (2007) report low educational levels are associated to an increase in stigma or negative attitudes toward mental health. Steele et al.'s finding is

consistent with other literature which identifies low educational levels as being associated with poor self awareness when it comes to mental illness. Steele et al. also identify a relationship between low educational level and employment that result in a decrease in utilizing mental health services, which may be due to the fact that less educated people tend to work together and due to social pressure and uninformed information those who need services resist using them.

Social Control

Rook, Thuras, and Lewis (1990) point out that Durkheim was the first researcher to focus on the use of social control as a means to achieve compliance with people in regard to norms and healthy behavior. According to Rook et al., social control is largely understudied in the elderly population as related to dealing with health problems. Social control can be exhibited in many ways, such as norms, values, social ties, laws and regulations, and responsibilities. Having people follow expectations so that they are taking appropriate care of their health issues is a role of social control. Many times this can be accomplished through informal social ties such as family and friends, and other times it requires a more formal approach.

Rook et al. (1990) find social control factors to have little impact of the elderly and their health activities. People are more influenced by social peers and family more so than by spouses. In some cases utilizing social influences on the elderly to adhere to medications compliance can result in the opposite effect (Rook et al., 1990).

Cutrona, Russell, and Rose (1986) have examined how social support impacted the mental health of elderly persons. The findings indicate that the elderly who have high numbers of social support systems tend to cope with stressful situations better than

those who lack sufficient social support (Cutrona et al., 1986). Social support systems can be considered a type of social control when those providing support influence the interventions of those in distress. Since elderly individuals with an adequate social support system have better coping skills, those providing support may have greater control or influence over their decisions.

Fear

There are a variety of ways that one can experience fear. As it relates to mental health, it can be the unknown of the illness, the fear of what others might think (stigma) or even what might occur if diagnosed with a mental illness. Robb, Haley, Becker, Polivka, and Chwa (2003) have discovered that many elderly fear placement in a long-term care facility and therefore avoid mental health treatment options as a result. This fear can be due to a lack of knowledge and accurate information about mental illness. According to Leaf et al. (1987), a large number of individuals in their study reported that they had a fear that family would get angry if they sought treatment for their mental illness. This is fear of discovery of using mental health services is one that many people face.

Income

Leaf et al. (1987) report socioeconomic status has a great ability to sway attitudes on mental illness. From this belief, spans numbers of other attitudes relating to mental illness. Leaf et al. state lower socioeconomic groups are concerned about the thoughts of others, face monetary difficulties, and are simply less likely obtain mental health treatment. This can be cause of great concern as this group is often in great need of such services (Leaf et al., 1987).

Dobalian and Rivers (2008) have discovered income has an impact on age, gender, and ethnicity when it comes to utilizing mental health services. Dobalian and Rivers find among women, those in the lower income brackets tend to use mental health services more than others. Along with that, Dobalian and Rivers report elderly individuals in the lower and upper income categories tend to use mental health services more than other elderly persons. Dobalian and Rivers have determined income has an impact on almost every demographic category except for ethnicity, specifically except for White people. To address the impact that income has on mental health treatment, attention should be placed on the lower socioeconomic groups and ethnic minorities (Dobalian & Rivers).

Race/Ethnicity

Leaf et al. (1987) report non-Whites are more likely to utilize religious sources for mental health services than Whites. This tendency may be related to the cultural belief that mental illness is a sign of punishment or immoral living. Diala et al. (2000) report African Americans tend to utilize mental health services less than Whites in part due to their misinformation about such services. When looking at African Americans and Whites with no history of using mental health services, African Americans reported a more positive attitude (Diala et al.). However, once each member has utilized services, Whites have a more positive attitude than do African Americans (Diala et al.). Dobalian and Rivers (2008) conclude that even removing certain barriers such as income and medical coverage, African Americans are still at risk not to utilize mental health services.

Atkinson and Gim (1989) discuss how many of the traditional Asian cultures have beliefs that would make people from those countries have a negative view of mental health services. After conducting their research, Atkinson and Gim (1989), conclude that Asians who are more assimilated into American society have more favorable views of mental health services than those who are not assimilated. This finding supports the proposition that ethnicity can have an impact on attitudes shared by people.

Among all ethnic groups, Hispanics and African Americans are less likely than Whites to utilize mental health services (Dobalian & Rivers, 2008). This also carries over into the Hispanics and African American groups who may have the preexisting condition of depression (Dobalian & Rivers).

Research Statement

The primary research question to be answered in this study was: Do the attitudes of fear, social control, and goodwill have an impact upon retirees and influencing their attitude toward mental illness treatment? Secondly, whether any of the differences can be explained by the life-course perspective via (1) ethnicity, (2) years of education, (3) gender, (4) income, and (5) personal experience was examined.

Hypotheses

The research hypothesizes employed in the study follow. For each a hypothesis, a figure is shown to depict the hypothesis (Figures 1-8).

H1: Retirees with low income will have a negative attitude toward mental illness treatment.

	Positive Treatment	Negative Treatment
Low Income		X
High Income		

Figure 1. The hypothesis of low income toward mental illness treatment.

H2: Retirees with low education will have a negative attitude toward mental illness treatment.

	Positive Treatment	Negative Treatment
Low Education		X
High Education		

Figure 2. The hypothesis of low education toward mental illness treatment.

H3: Retirees with no personal experience will have a negative attitude toward mental illness treatment.

	Positive Treatment	Negative Treatment
No Personal Experience		X
Personal Experience		

Figure 3. The hypothesis of no personal experience toward mental illness treatment.

H4: Retirees who are non-White will have a negative attitude toward mental illness treatment.

	Positive Treatment	Negative Treatment
Non-White		X
White		

Figure 4. The hypothesis of non-Whites toward mental illness treatment.

H5: Retirees who are male will have a negative attitude toward mental illness treatment.

	Positive Treatment	Negative Treatment
Male		X
Female		

Figure 5. The hypothesis of gender toward mental illness treatment.

H6: Retirees with low good-will will have a negative attitude toward mental illness treatment.

	Positive Treatment	Negative Treatment
Low Good-Will		X
High Good-Will		

Figure 6. The hypothesis of low good-will attitude toward mental illness treatment.

H7: Retirees with high fear will have a negative attitude toward mental illness treatment.

	Positive Treatment	Negative Treatment
Low Fear		
High Fear		X

Figure 7. The hypothesis of high fear attitude toward mental illness treatment.

H8: Retirees with high social control will have a negative attitude toward mental illness treatment.

	Positive Treatment	Negative Treatment
Low Social Control		
High Social Control		X

Figure 8. The hypothesis of high social control attitude toward mental illness treatment.

Summary

Upon review of the literature, the independent variables and intervening variables were determined to be appropriate choices for measuring the impact that retirees' attitudes have regarding mental illness treatment. The literature was quite extensive and provided a good foundation for investigating the causes of retirees' attitudes. The example questions described in the above discussion were not all inclusive. Additional questions from the original study could be included and substituted as deemed necessary for the present study.

CHAPTER 3

METHODOLOGY

The collection and management of the data are discussed in this chapter. The following topics are included: (1) Introduction, (2) setting, (3) population and sample, (4) protection of human subjects, (5) instruments, (6) variables, and (7) data collection.

Introduction

This research was conducted using secondary data from the Survey Research Center at the University of North Texas. This section discusses the how the original methodology was carried out. After reviewing the literature, it appears that several variables impact attitudes toward mental health treatment. Independent variables include: (1) personal experience, (2) gender, (3) ethnicity, (4) income and (5) education. There are three intervening variables that consist of: (1) fear, (2) goodwill and (3) social control; while the dependent variable is attitude toward treatment. There is a consequential variable of policy, which is addressed in the discussion section. The consequential variable is defined as the implications and possible applied policy changes that result from the findings. Participants in the survey were asked a series of questions adapted from other mental health surveys and clinical studies. The questions were assembled into a telephone survey instrument by the University of North Texas Survey Research Center. Trained telephone interviewers and utilized random digit dialing to contact residences. Included in the survey was demographic information that resulted in the dependent variables. Along with the demographic information, a series of vignettes were read to each participant. From this each participant was asked a series of questions that addressed the intervening variables. The relationships of variables

associated with treatment were conducted using frequency analysis and binary logistic regression analysis.

Setting

The study took place in Tarrant County, Texas, in conjunction with the Mental Health Collaboration of Tarrant County and the University of North Texas Survey Research Center. The participants were recruited by using random digit dialing service to call telephones.

Population and Sample

The population consisted of all residents that live inside Tarrant County, Texas. From this population, a sample was generated by using random digit dialing to access the participants. In order to be included in the survey the participants had to: (1) have a land line telephone, (2) be at least 18 years of age, (3) speak English, and (4) live in Tarrant County. This subsample of 225 comprised the sample in this study.

Protection of Human Subjects

This study is utilizing secondary data and no participants will be interviewed for the data used in this paper. The Institutional Review Board (IRB) of the University of North Texas provided consent for this study (see Appendix A). All identifying information was omitted from the data when the data were provided for this study. There can be no release or harm caused to any individual as a result of this survey.

Instruments

The instrument was created by the Survey Research Center staff of the University of North Texas using multiple sources. The Survey Research Center staff worked in conjunction with the Mental Health Collaboration of Tarrant County members

to identify the attitudes they wished to measure, then a draft instrument was created. A literature review was preformed to locate measures from prior survey and clinical studies that could be adapted to a telephone survey. The final instrument consisted of (1) demographic data, (2) vignettes, and (3) general questions toward attitudes.

Variables

The dependent variable for the study was attitude toward mental illness treatment. The independent variables for the study were income, education, gender, and ethnicity. The intervening variables for the study were social control, fear, and goodwill. The consequential variable was policy. Figure 9 represents the variables for the study.

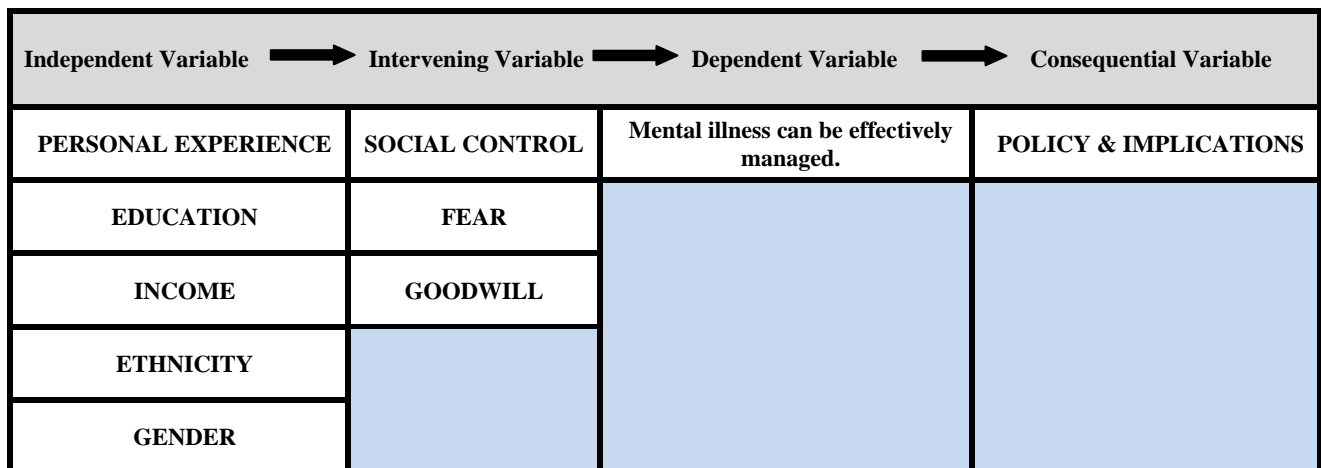


Figure 9. Visual depiction of the direction of the study’s variables and how they interact with one another.

Data Collection

Being that this study used secondary data, no data collection procedures were needed (see Appendix B). However, an explanation of the original study and the data collection methods used is appropriate. Representatives of the Survey Research Center

of the University of North Texas conducted telephone interviews with 1,100 residents of Tarrant County, Texas. The telephone interviews were used to examine the attitudes of Tarrant County residents toward mental illness. Utilizing a random digit dialing program, the trained interviewers asked each participant a series of questions and read vignettes to the participants to gather information on their attitudes toward mental illness.

The participants were not provided any incentive for their participation in the survey. The participants were advised of the purpose of the study and consented to be part of the study. Each trained interviewer documented their interactions with the participants and coded the data using non-identifying methods.

Summary

Data for this research study were secondary data and used with the permission of the Survey Research Center of the University of North Texas and the Mental Health Collaboration of Tarrant County. A total of 1,100 responses generated in the original study were made available for the present study. A total of 225 responses made by retirees were used for the data of analyzed in the current study.

CHAPTER 4

RESULTS

Introduction

This chapter examines the data utilized in this study and discusses the findings. The data were gathered from an existing study conducted in 2004 by the Survey Research Center at the University of North Texas. From the original 2004 study data, 225 respondents met the criteria for being retirees. Frequency analysis was utilized to determine the distribution of the variables and to clarify how the variables needed to be categorized. Binary logistic regression was utilized for the analysis on the data.

Hypotheses

The hypothesis of this study was that having higher education; being White; having higher income; having low belief in social control, low fear, and high belief in goodwill; being female; and having prior experience with mental illness or the mentally ill would result in more favorable attitudes toward mental illness treatment.

Independent, Intervening, and Dependent Variables

The dependent variable for the study was attitude toward mental illness treatment. The independent variables for the study were income, education, gender, and ethnicity. The intervening variables for the study were social control, fear, and goodwill. The consequential variable was policy. Figure 9 in Chapter 3 represented the variables and their logic flow.

Independent Variables

Gender was easily categorized into either male or female responses. Education was broken down into a dichotomous variable that consisted of two categories:

(1) some college and above; (2) all others. Race/Ethnicity was categorized into two groups consisting of White and all others. Prior mental health experience was created by transforming two questions from the original survey into one:

1. Have you or a member of your household ever undergone mental health counseling or taken medications for mental health reasons?

1 YES

2 NO

9 DK/NR (i.e., don't know/no response)

2. Are you or any member of your family in contact with people with mental illness, either professionally, or within the scope of your work as a volunteer?

1 YES

2 NO

9 DK/NR

After transforming the old variables into one new variable, the new item was categorized into dichotomous response options of either yes or no.

Income had multiple missing data which were filled in by predicting the values using responses to other questions (see Table 1). Income was turned into a scale by using the mid-points of each existing category and assigning the mid-point values coded in the following manner presented in Table 1.

Table 1

Income Scale Using Mid-points

Original Value	Mid-point	Coded Value
Under \$10,000	\$5,000	.500
\$10,001 to \$20,000	\$15,000	1.500
\$20,001 to \$30,000	\$25,000	2.500
\$30,001 to \$40,000	\$35,000	3.500
\$40,001 to \$50,000	\$45,000	4.500
\$50,001 to \$75,000	\$62,500	6.250
\$75,001 to \$100,000	\$87,500	8.750
Over \$100,000	\$125,000	12.500

Table 2 shows the prior mental health experience data distribution for the independent variables of gender, education, and race/ethnicity. Gender had a distribution of 145 (64.4%) females and 80 (35.6%) males. Education had a distribution of 71 (31.6%) in the “all others” category and 154 (68.4%) respondents in the “some college and above” category. Race/Ethnicity had a distribution of 30 (13.5%) in the “all others” category and 193 (86.5%) respondents in the “White” category. “Prior mental health experience” had a distribution of 122 (54.7%) who responded “No” and 101 (45.3%) who responded “Yes.”

Table 2

Distribution of Independent Variables of Gender, Race/Ethnicity, Education, and Prior Mental Health Experience

Variable	<i>n</i>	Percentage
<u>Gender</u>		
Female	145	64.4
Male	80	35.6
Total	225	100.0
<u>Education</u>		
All Others	71	31.6
Some College and Above	154	68.4
Total	225	100.0
<u>Race/Ethnicity</u>		
All Others	30	13.5
White	193	86.5
Total	223	100.0
Missing Data	2	
<u>Prior Mental Health Experience</u>		
Yes	101	45.3
No	122	54.7
Total	223	100.0
Missing Data	2	

Table 3 shows the distribution of the independent variable of income. Income had a distribution of 15 (6.9%) at .500, 24 (11.1%) at 1.500, 33 (15.3%) at 2.500, 24 (11.1%) at 3.500, 29 (13.5%) at 4.500, 35 (16.2%) at 6.250, 11 (5.1%) at 8.750, and 15 (6.9%) at 12.500. Another 30 (13.9%) were estimated and ranged from 1.947 to 7.036.

Table 3

Distribution of Independent Variable of Income

Income	<i>n</i>	Percentage
0.500	15	6.9
1.500	24	11.1
1.947	1	.5
2.053	1	.5
2.174	1	.5
2.390	1	.5
2.500	33	15.3
2.654	1	.5
3.040	1	.5
3.500	24	11.1
4.084	2	.9
4.090	1	.5
4.195	1	.5
4.200	1	.5
4.241	1	.5
4.358	1	.5
4.416	2	.9
4.500	29	13.4
4.533	1	.5
4.638	2	.9
4.749	1	.5
4.860	2	.9
4.950	1	.5
5.104	1	.5
5.729	1	.5
6.112	1	.5
6.250	35	16.2
6.328	1	.5
6.392	1	.5
6.439	1	.5
6.747	1	.5
7.036	1	.5
8.750	11	5.1
12.500	15	6.9
Total	216	100.0
Missing Data	9	

Intervening Variables

The objective was to have all three intervening variables as scales, but due to an insufficient Cronbach's alpha coefficient on goodwill (.538) that was not possible. Even when the scale examined without the removed items, the reliability coefficient did not rise above .538. As a result, the goodwill variable was created from selecting one question from the original survey that best represented the concept of goodwill and then categorized into dichotomous responses consisting of "strongly agree" and "all others." The item used for goodwill follows:

1. People with mental illness may lead a normal life given appropriate help

- 1 Strongly Disagree
- 2 Disagree
- 3 Agree
- 4 Strongly Agree
- 9 DK/NR

Fear was transformed into a scale using the following questions for the original survey:

1. I would not want to live next door to someone who has been mentally ill.

- 1 Strongly Disagree
- 2 Disagree
- 3 Agree
- 4 Strongly Agree
- 9 DK/NR

2. I would not want to work with someone who had a mental illness.

1 Strongly Disagree

2 Disagree

3 Agree

4 Strongly Agree

9 DK/NR

3. I would not want my child to be friend with a child with a mental illness.

1 Strongly Disagree

2 Disagree

3 Agree

4 Strongly Agree

9 DK/NR

4. The mentally ill should be isolated from the rest of the community.

1 Strongly Disagree

2 Disagree

3 Agree

4 Strongly Agree

9 DK/NR

A Cronbach's alpha was run for the 4-item fear scale and the coefficient for the scale was .730, a value sufficient for keeping fear as a scale. The fear scale was coded into four categories consisting of *strongly disagree*, *disagree*, *agree*, and *strongly agree*.

Social control was transformed into a scale using the following questions from the original survey instrument:

1. As soon as a person shows signs of mental disturbance he should be hospitalized
 - 1 Strongly Disagree
 - 2 Disagree
 - 3 Agree
 - 4 Strongly Agree
 - 9 DK/NR
2. Anyone with a history of mental problems should be excluded from public office
 - 1 Strongly Disagree
 - 2 Disagree
 - 3 Agree
 - 4 Strongly Agree
 - 9 DK/NR
3. There is something about the mentally ill that makes it easy to tell them from normal people
 - 1 Strongly Disagree
 - 2 Disagree
 - 3 Agree
 - 4 Strongly Agree
 - 9 DK/NR
4. As soon as a child exhibits a mental illness in school they should be placed in an alternative setting
 - 1 Strongly Disagree

- 2 Disagree
- 3 Agree
- 4 Strongly Agree
- 9 DK/NR

A Cronbach's alpha was run for the four item social control scale and the coefficient for the scale was .645. While this value was below the standard of .700, and since this was an intervening variable, the decision to keep the scale was made. The social control scale was coded into four categories consisting of strongly disagree, disagree, agree, and strongly agree.

The distribution of the intervening variables is presented in Table 4. Goodwill had a distribution of 65 (29.5%) responding for the strongly agree category and 155 (70.5%) responding for the "all other" category. Fear scale had a distribution of 5 (2.5%) respondents for the strongly disagree category, 19 (9.9%) for the disagree category, 69 (35.9%) for the agree category, and 99 (51.5%) for the strongly agree category. Social control scale had a distribution of 22 (11.4%) respondents for the strongly disagree category, 46 (23.9%) for the disagree category, 88 (45.9%) respondents for the agree category, and 36 (18.8%) for the strongly agree category.

Table 4

Distribution of the Intervening Variables of Goodwill, Fear, and Social Control

Variable	N	Percentage
<u>Goodwill</u>		
Strongly Agree	65	29.5
All Others	155	70.5
Total	220	100.0
Missing Data	5	
<u>Fear</u>		
Strongly Disagree	5	2.5
Disagree	19	9.9
Agree	69	35.9
Strongly Agree	99	51.5
Total	192	100.0
Missing Data	33	
<u>Social Control</u>		
Strongly Disagree	22	11.4
Disagree	46	23.9
Agree	88	45.9
Strongly Agree	36	18.8
Total	192	100.0
Missing Data	33	

Dependent Variable

The intent was to have the dependent variable consist of a scale using the following questions from the original survey:

1. Modern drugs can control mental illness

1 Strongly Disagree

2 Disagree

3 Agree

4 Strongly Agree

9 DK/NR

2. Mental illness can be effectively managed

1 Strongly Disagree

2 Disagree

3 Agree

4 Strongly Agree

9 DK/NR

3. Children with mental illness can grow up to be productive adults

1 Strongly Disagree

2 Disagree

3 Agree

4 Strongly Agree

9 DK/NR

4. People with mental illness may lead a normal life given appropriate help

1 Strongly Disagree

2 Disagree

3 Agree

4 Strongly Agree

9 DK/NR

The Cronbach's alpha was run for the four item social control scale and the coefficient for the scale was .588. With a coefficient below .588 even after testing for reliability if items were deleted and no improvement in the coefficient's value, the dependent variable was transformed into a dichotomous categorical variable. The new variable was created by using a single question, because it best described the intent of the hypothesis: mental illness can be effectively managed. This variable was collapsed into two categories, "strongly agree" and "all others," due to the distribution of the data.

The distribution of the dependent variable is represented in Table 5. Attitude toward mental illness treatment had a distribution of 118 (56.2%) in the "strongly agree" category, 92 (43.8%) in the "all other" category.

Table 5

Distribution of the Dependent Variable of "Mental Illness can be Effectively Managed"

Attitude Toward Mental Illness Treatment	N	Percentage
All Others	92	43.8
Strongly Agree	118	56.2
Total	210	100.0
System Missing	15	

Data Analysis

The result from the binary logistic regression analysis using all the predictor variables is reported in Table 6. No statistical significance occurred all of the variables were included in the analysis. While this result was disappointing, lack of significance is worth reporting and brings many issues into question to be addressed in Chapter 5.

Table 6

Binary Logistic Regression Analysis for All Independent and Intervening Variables on Attitude Toward Mental Illness Treatment

Predictor	<i>B</i>	S.E.	Wald	<i>df</i>	<i>p</i>
Prior Experience	-0.304	.357	.725	1	.395
Income	-0.006	.066	.009	1	.994
White/Non-White	0.583	.475	1.509	1	.219
Goodwill	-0.297	.368	.651	1	.420
Gender	0.063	.381	.028	1	.868
Education (Some College and Above)	0.619	.433	2.046	1	.153
Social Control	0.009	.071	.016	1	.898
Fear	-0.135	.082	2.702	1	.100
Constant	1.149	1.133	1.029	1	.310

After running the initial analysis and finding no significant results, an attempt to run multiple new analyses was undertaken. Combining and omitting different variables to determine if any combination could produce significant results yielded minimal results. There was a combination of variables that did produce significant results; and that was running the binary logistic regression using only prior mental health experience, gender, education, and fear. Using this analysis, people with a level of education of at least some college appeared to have a more positive attitude toward mental illness treatment, $p=.008$ (see Table 7). This relationship is positive indicating the more education people have, the more positive attitude they have toward mental illness treatment. Fear represented the second significant finding, $p=.029$ (see Table 7). This fear and attitude toward mental illness treatment had a negative relationship,

meaning a lower score on fear would result in a higher positive attitude toward mental illness treatment.

Table 7

Binary Logistic Regression Analysis for Fear, Education, Gender, and Prior Mental Health Experience Variables on Attitude Toward Mental Illness Treatment

Predictor	<i>B</i>	S.E.	Wald	<i>df</i>	<i>p</i>
Prior Experience	-0.386	.334	1.337	1	.248
Gender	0.066	.330	0.040	1	.841
Education (Some College)	0.936	.352	7.074	1	.008*
Fear	-0.159	.073	4.791	1	.029*
Constant	1.848	.963	3.681	1	.055

Note: * $p < .05$

The variable of Race/Ethnicity was added to the variables modeled in Table 8 to see if that would result in different significant findings. The analysis provided similar results to the ones produced above. Education with some college and above and fear appear to be the only variables that provide significant results. Race/Ethnicity did not alter the outcome in any significant manner ($p = .222$).

Table 8

Binary Logistic Regression Analysis for Fear, Education, Gender, Prior Mental Health Experience, and Race/Ethnicity Variables on Attitude Toward Mental Illness Treatment

Predictor	<i>B</i>	S.E.	Wald	<i>df</i>	<i>p</i>
Prior Experience	-0.356	.336	1.125	1	.289
Gender	0.003	.335	0.000	1	.992
Education (Some College)	0.843	.359	5.514	1	.019*
Fear	-0.158	.073	4.660	1	.031*
White/Non-White	.550	.450	1.492	1	.222
Constant	1.848	.963	3.681	1	.055

Note: * $p < .05$

Summary

To summarize the findings of this study, there were only two variables demonstrating a significant influence on attitude toward mental illness treatment. Those two variables were fear and education level of “some college or above.” A quick review of all the research questions led to the following results:

H1: Retirees with low income will have a negative attitude toward mental illness treatment. Utilizing binary logistic regression analysis, the results do not show any significant findings to support this hypothesis.

H2: Retirees with low education will have a negative attitude toward mental illness treatment. Utilizing binary logistic regression analysis, the results showed a positive correlation between education and attitude toward mental illness treatment. It appears that the more education a people had, in this case at least some college or above, the more favorable they felt toward mental illness treatment.

H3: Retirees with no personal experience will have a negative attitude toward mental illness treatment. Utilizing binary logistic regression analysis, the results did not show any significant findings to support this hypothesis.

H4: Retirees who are non-White will have a negative attitude toward mental illness treatment. Utilizing binary logistic regression analysis, the results did not show any significant findings to support this hypothesis.

H5: Retirees who are male will have a negative attitude toward mental illness treatment. Utilizing binary logistic regression analysis, the results did not show any significant findings to support this hypothesis.

H6: Retirees with low goodwill will have a negative attitude toward mental illness treatment. Utilizing binary logistic regression analysis, the results did not show any significant findings to support this hypothesis.

H7: Retirees with high fear will have a negative attitude toward mental illness treatment. Utilizing binary logistic regression analysis, the results showed a negative correlation between fear and attitude toward mental illness treatment. The more fear people expressed toward mental illness, the less positive they felt toward mental illness treatment.

H8: Retirees with high social control will have a negative attitude toward mental illness treatment. Utilizing binary logistic regression analysis, the results did not show any significant findings to support this hypothesis.

CHAPTER 5

DISCUSSION

Review of Analysis

This chapter addressed the analysis of the study and the implications of the findings, including applied meanings and recommendations for future research study. A discussion would not be complete without a thorough examination of the limitations of the study, thus a review of the short-comings of the study will be discussed.

Summary of Study

This study was conducted using secondary data from a prior study completed by the University of North Texas Survey Research Center. The primary objective of this study was to determine what, if any variables from the study, impact the attitude of retirees toward mental illness treatment. Findings from this study as they related to the variables are examined here.

As it pertains to education, there was a significant finding. From the findings of this study, there appears to be a positive correlation to education. As education increases, the more positive the attitude toward mental illness. This finding supports what the literature review revealed. As it pertains to prior personal experience, there were no significant findings revealed. This finding was contrary to the literature review. As it pertains to gender, there was no significant finding revealed which was also contrary to the literature review. As it pertains to income, there was no significant finding revealed, which was contrary to the literature review. As it pertains to race/ethnicity, there was no significant finding revealed, which was contrary to the literature review.

As it pertains to fear, there was a significant finding. The results of the analysis

showed a negative correlation between fear and attitude toward mental illness treatment. The higher the fear people had toward mental illness, the lower their positive attitude toward mental illness treatment. This finding supports the information from the literature review. As it pertains to social control, there was no significant finding revealed. This finding was contrary to the findings in the literature review. As it pertains to goodwill, there was no significant finding revealed. This finding was contrary to the finding in the literature review.

Limitations of the Study

There were several limitations to this study. The most significant limitation to this study is the fact that there was no age variable. Due to this study being conducted utilizing secondary data, this researcher had to work with the data provided. In the original study, the researchers omitted the variable of age, most likely an oversight. In order to obtain a sample of elderly individuals, the question of employment was utilized. In the employment variable, several categories were listed, one being retired. Those who identified as being retired were selected into the sample group. The problem lies in the fact that the age of those who identified as being retired was an unknown. This makes the variable of retired an unknown for specific age.

The survey was conducted in only one county, Tarrant County, in the State of Texas. The fact that all respondents were located in a centralized area, omits diversity in the sample. Being that the sample came from a single geographic area, the results may not be generalizable to the public at large.

The survey was conducted over the telephone and could have missed individuals who did not have a one. As a result of the interaction with a live person, the

respondents could have given responses they felt were socially desirable. The distribution of the responses had an impact on the study as well. The majority of the data were unevenly distributed. One hundred ninety-three (85.8%) respondents reported being White, out of a sample of 225 respondents; therefore, there was a lack of proper representation of other racial or ethnic groups. Another problem with the data was the large number of missing responses, especially for income.

Implications

The implications for this study relate to the influence that education and fear have on attitudes toward mental illness treatment. The applied, educational, and policy implications are discussed. How this information can be applied is the important part of this section. Understanding that retirees with at least some college and above would be more likely to utilize mental health services themselves or support a person they know to seek mental health service is important. The reason for the significance of this is so that an assessment of the services available to retirees seeking mental illness treatment can be conducted. Ensuring adequate mental health services, providers, and resources for this cohort of retirees is important to providing quality care. Making sure that clinicians who provide mental health services to retirees are trained and educated about the specific needs of this cohort is going to be important. Providing education to mental health professionals about the effects of fear and lack of formal education on a person's willingness to access mental illness treatment is going to be important. This will allow professionals to address barriers to treatment for retirees.

An examination of the current health care policies toward mental health services should be made to ensure that adequate attention has been placed on this topic. Being

that most retirees will rely upon Medicare as their primary resource for funding mental health services; the funding and accessibility to mental health services should be addressed. The Mental Health Parity Act (MHPA) attempts to address the issue of funding. However, the MHPA does not address the issue of funding for public service announcements to assist in educating about the benefits of mental illness treatment. One step that could be taken is to focus public service announcements toward the issue of fear. By attempting to reduce the fear people may have toward mental illness treatment, the number of people utilizing mental illness treatment could increase. If the next cohort of retirees has more education and less fear toward mental illness treatment, the current status quo of providers may not be sufficient to meet future needs.

As time goes by, society is less fearful of mental illness. The stigma that exists today, while still prevalent, is minimal compared to what the stigma was 20, 30, or even 50 years ago. What this means is, as future cohorts of retirees emerge, they are likely to have less fear regarding mental illness than previous cohorts. With less fear comes a more accepting and positive attitude toward mental illness treatment. Ensuring that society is able to meet the future needs of its retirees is important and can be done by providing education to the public regarding mental illness and the importance of treatment.

Recommendations for Future Study

While this study was able to replicate findings of past studies, some interesting questions that would make intriguing inquiries for future studies. The recommendations are listed below:

1. Examining what are the variables that cause a person to be fearful of mental illness treatment or the mentally ill.

2. Determining if education about mental illness can be a substitute for formal education.

3. Comparing retirees and non-retirees to identify if there are any differences in attitudes toward mental illness treatment.

4. Conducting this study on a large sample group.

5. Duplicating this study on a larger geographical area than just small area, such as a county or large city.

6. Repeating this study with a specific age category.

APPENDIX A
INSTITUTIONAL REVIEW BOARD LETTER



OFFICE OF THE VICE PRESIDENT FOR RESEARCH AND ECONOMIC DEVELOPMENT

July 3, 2009

Thomas Starkey
Department of Applied Gerontology
University of North Texas

RE: Human Subjects Application No. 09-260

Dear Mr. Starkey:

In accordance with 45 CFR Part 46 Section 46.101, your study titled "Retiree's Attitudes Towards Mental Illness Treatment: A Lifecourse Perspective." has been determined to qualify for an exemption from further review by the UNT Institutional Review Board (IRB).

No changes may be made to your study's procedures without prior written approval from the UNT IRB. Please contact Jordan Smith, Research Compliance Assistant, ext. 3940, if you wish to make any such changes. Any changes to your procedures after 3 years will require completion of a new IRB application.

We wish you success with your study.

Sincerely,

Patricia L. Kaminski, Ph.D.
Associate Professor
Chair, Institutional Review Board

PK:js

CC: Dr. Stan Ingman

APPENDIX B

APPROVAL LETTER FROM SURVEY RESEARCH CENTER

UNIVERSITY OF NORTH TEXAS

June 1, 2009

To whom it may concern:

The purpose of this letter is to authorize the release of data from the UNT Survey Research Center to be used in the dissertation of Tom Starkey. The data are from the project, "Tarrant County Mental Health Attitudes Survey 2004" performed for the Mental Health Collaboration of Tarrant County.

We have obtained permission from the grant administrator, the city of Fort Worth Health Department's Daniel B. Reimer to use the data for this purpose.

Sincerely,



Paul Ruggiere
Director

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