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Dimensionality underlying attributions towards mental illness /

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DIMENSIONALITY UNDERLYING ATTRIBUTIONS TOWARDS MENTAL ILLNESS

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Abstract

This study aims to test the assumption of two dimensions of etiology and treatment underlying attributions towards mental illness (Hill and Bales 1980 and Brickman et al 1982). The two major issues are the evidence for dimensionality underlying attributions towards mental illness, and the influence of demographic and social variables on these attributions.

Factor analysis of a questionnaire tapping attributions towards mental illness from providers and consumers of mental health services revealed seven factors. A forced factor analysis of three factors allowed for a more meaningful comparison of the results to Hill and Bales and Brickman et al. The results indicated that, a) causal factors are based on external or internal etiology beliefs, b) treatment items also load on these factors according to which type of treatment matches the cause, offering support for Hill and Bales' finding of a correlation between etiology and treatment, c) a factor of "diagnosis" implies that causality may be broken down into specific issues concerned with how the label of mental illness is assigned. A complex framework of more than two dimensions is needed to explain attributions towards mental illness even though some of the ideas implicit in the assumption of two dimensions are apparent, for instance, the relationship between etiology and treatment. A comparison of providers and consumers suggests that even though a similar framework is used, these populations use different criteria for making attributions under this framework.

An analysis of variance on the demographic variables of the providers and consumers and their scale scores derived from the factors, indicated that attributions are also influenced by variables such as occupation, qualifications, age, previous treatment, and other factors.

Chapter 1

Introduction and Statement of Problem

The issue of attitudes towards mental illness has been the subject of much research, not least because of the effect these attitudes can have on the subsequent treatment of the problem. In effect, the type of treatment given can depend on how society as a whole and individuals within the society view mental illness. Therefore, it is important first and foremost to be aware of what mental illness means to the public and also to the professionals involved in providing treatment.

A working definition of an attitude has three elements: affect (feelings), behavior, and cognition (beliefs). In research on attitudes towards mental illness, feelings, behavior, and beliefs have all been assessed and provide us with some understanding of peoples "attitudes" to mental illness. However, the research has, on the whole, produced conflicting results and not managed to come to any clear conclusions as to the nature of these attitudes.

The early work, up to the 1970s, saw attitudes as simple reactions to "mental illness". This gave way to the acknowledgement that "mental illness" may be a social construction, that is, a label and not an objective disease, and more recently, attitudes have been viewed as part of a larger cultural context. However, up to the present time research has tended, on the most part, to ignore the aspect of attributions of causality of mental illness, that is, the beliefs about what causes mental illness. I believe that in order to provide the most beneficial and effective treatment for individuals, their beliefs about treatment in terms of who takes control and assumes responsibility for change in the treatment situation are important. However, these beliefs can only be fully

understood by considering the individual's beliefs about the causality of mental illness.

Research on attributions towards mental illness has assumed the existence of two two independent dimensions; attributions of causality and attributions of responsibility/control in treatment. However, there has been little empirical data offered to verify this assumption. It may be the case that only one dimension is used when making judgments about mental illness. Similarly, more than two dimensions might be necessary. Furthermore, the nature and definitions of the dimensions have varied, although on first glance they appear to be the same. This tends to make it difficult for a comparison to be made between the frameworks that are available in the research. These frameworks are offered by the medical model, Brickman et al, Hill and Bales, and Karanci.[1]

The medical model portrays mental illness in the same way physical illness is portrayed, that is, as a disease. Within this view there is the implied notion of two independent dimensions, attributions of causality and attributions of responsibility in treatment. Specifically, mental illness and physical illness are viewed as "internal" problems that the individual does not have control over, or responsibility for. Furthermore, treatment should be offered in the same vein, that is, the individual is not held responsible for treatment but rather accepts external help to "cure" the problem.

Brickman et al (1982) looked more specifically at the attributions of responsibility for the problem and the solution and constructed a conceptual framework to explain these attributions. Underlying the framework was again the assumption of two orthogonal dimensions; causes of mental illness and responsibility in treatment.

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[1]A note should be made here concerning the use of the terms "dimensions" and "factors" throughout this paper. "Factors" will be used as the operational realization of the theoretical construct, "dimension".

The implications of this assumption led Brickman et al to develop four models based on the four possible combinations of the client being responible or not for the problem and the solution. The four models are: the medical model, moral model, compensatory model, and enlightenment model.

Hill and Bales (1980), also assumed there to be two independent dimensions concerned with attributions towards mental illness. In addition, Hill and Bales supplied a measure of the dimensions in the two scales they developed, the Mental Health Locus Of Origin (MHLO), and the Mental Health Locus Of Control (MHLC). In other words, Hill and Bales operationalized the "dimensions" with the arbitrary construction of two "scales".

The MHLO measures beliefs about what Hill and Bales believed to be etiology of mental illness, (the two poles are physiology and genetics versus interactions with the environment). The MHLC measures what Hill and Bales thought were beliefs about who has control/responsibility in the treatment situation, the therapist or the client, (internal versus external locus of control). Hill and Bales also found a positive correlation between the MHLO and the MHLC.

However, Brickman et al and Hill and Bales do not provide any empirical research to verify the existence of the two dimensions they propose.

Karanci (1986) was mainly concerned with the issue of causality of mental illness, and in contrast to Brickman et al and Hill and Bales who suggest a bipolar dimension, with poles of being responsible-not being responsible, internal causes-external causes respectively, Karanci reported the results of a factor analysis of attributions in the domain of etiology. He found three factors, a) the individual is to blame, b) no-one is to blame, and c) others are to blame. Although Karanci is not concerned with the treatment dimension, he does talk about the implications of the

scores on these factors for treatment and examines the predictive power of the measured attributions in terms of hope for future well-being and the subsequent role of the client in the treatment setting.

In sum, research has been inconclusive about the dimensions underlying attributions towards mental illness. Brickman et al, Hill and Bales and Karanci all recognize an etiology dimension in these attributions, although they vary on the nature of this dimension. Hill and Bales and Brickman et al assume the etiology dimension is bipolar whereas Karanci suggests that there are three dimensions within the domain of etiology. However, Karanci's findings are open to interpretation, and I propose that the three factors he derived can be reduced to two, individual to blame and individual not to blame, and thus can be represented conceptually by a bipolar dimension in the same manner as Hill and Bales and Brickman et al. A second bipolar dimension, concerned with treatment, is also suggested by Hill and Bales; Karanci merely notes the implications of etiological beliefs on treatment and does not directly talk about a treatment dimension.

As well as the nature of the dimensions varying, there are also differences in the definition given to the dimensions. Brickman et al and Karanci support the notion of responsibility in etiology and treatment whereas Hill and Bales only recognize it in the treatment situation.

The main concern that presents itself is the lack of empirical investigation of the existence of the dimensions. Hill and Bales and Brickman et al certainly do not provide any analysis to support the assumption of their theoretical dimensions. Karanci, however, carried out a factor analysis on a thirty-one item questionnaire concerned with the causes of mental illness to determine the nature of the dimensions on which people make attributions towards mental illness. The interpretation of his

findings can be questioned though, and as he is not directly concerned with the treatment dimension he offers no empirical data here.

Therefore, in addition to the problem of lack of research on dimensionality underlying attributions towards mental illness, there is also the problem of the variability in number, nature and definitions of these dimensions.

The present study aims to test some of the assumptions that are present in the literature reviewed here and hopefully shed some light on the conflicting ideas in the field of dimensionality and attributions towards mental illness.

There are two major issues that will be dealt with in the attempt to test the assumptions. The first one is to examine the very basis of the research discussed above, that is, what evidence is there for dimensionality underlying attributions towards mental illness. In short, is there an underlying structure to the area of attributions towards mental illness. If there are dimensions, the next question is how many dimensions are there. Thirdly, what is the nature of the dimensions, and how should they be defined.

A questionnaire is used to tap attributions to mental illness in a sample of providers and consumers of mental health services. Questions about the causes of mental illness and the treatment situation are represented on the questionnaire. A factor analysis is carried out on the questions.

Karanci's study used a Turkish sample and brought to light the fact that populations may vary cross-culturally with respect to the attributions they hold towards mental illness. Therefore, there may also be differences between sub-populations in the same culture. These differences may be due to SES, age, race and other social variables. With this in mind, providers and consumers of mental health

services will be compared with respect to their attributions.

The second issue is concerned with the influence of demographic and social variables on the attributions of providers and consumers. It is quite possible that the complex dimensionality of attributions towards mental illness is due implicitly to differences in sociodemographic variables and not merely based on the criteria of locus of control or responsibility.

Chapter 2

Literature Review

HISTORICAL BACKGROUND OF ATTITUDES TOWARDS MENTAL ILLNESS

The earlier research in attempting to understand attitudes towards mental illness became split into two camps: those who believed that the mentally ill were rejected versus those claiming that the mentally ill were accepted. This division rests on research assessing public knowledge (poorly informed versus well informed), social distance (high versus low), and definition of mental illness (dangerous versus sick).

Although in the 1970s this division still existed, research also tended to emphasize under what circumstances a particular behavior is rejected, and how this relates to other variables such as treatment provided for the mentally ill.

The issue of whether mental illness is in fact a "label" or a "disease" was also emerging as an important concern, particularly for research focusing on the public's definition of mental illness. Thus, there had been a shift away from an assumption of mental illness as an objective reality existing "out there" (with attitudes towards it measured by social distance, public knowledge, and descriptions of behavior indicative of mental illness), towards mental illness being considered a social construct that is necessarily subjective and open to interpretation.

This leaning towards questioning previously held assumptions about what constitutes mental illness leads to the notion that mental illness may, and should, be viewed as part of a larger cultural context. Hence, attitudes should not be seen as isolated "beliefs" towards mental illness but rather as part of a whole conceptual system that individuals are a part of, and which can also influence those individuals.

This also means that factors such as inferences about causality of mental illness are integral to this conceptual system, and thus to the individual's "attitude" towards mental illness.

Therefore, whether the public accepts or rejects mental illness need not be the only concern; it may be more beneficial to consider how attitudes affect the issue of helping individuals with mental health problems. As Rabkin (1981) noted, notions such as stigma and rejection, which have received so much attention, are too general when considering the practicality of what help can be given to those people suffering from a mental health problem.

In broadening the definition of attitudes, the focus is now directed away from just assessing "reactions" to mental illness and towards making judgments and inferences about the causes of an individual's behavior and the implications these inferences can have on the treatment of the problem. Attributions are thus not only an integral part of attitudes but the inclusion of them also means that a person's attitude can implicitly influence the judgments he/she makes concerning what the problem is, how it should be treated, and moreover, who assumes responsibility for this treatment.

ATTRIBUTIONS AND MENTAL ILLNESS

ATTRIBUTION THEORY

Attribution theory developed from Heider (1958), who wanted to understand how people explain everyday events. His conclusion was that people tend to attribute a person's behavior to either internal causes (dispositional) or external causes (situational). Heider also found that there was an apparent bias in attributions made about other peoples behavior. Specifically, individuals often fail to take into account the situation and circumstances surrounding the other persons behavior. Thus, there is an over-estimation of the role of stable personality traits influencing behavior. This is known as the "fundamental attribution error" (Jones and Nisbett 1972), and can be illustrated by observations that people tend to attribute others' actions to their personal dispositions even when the observers are likely to attribute a similar act on their own behalf to the prevailing situation and environmental factors.

The issue of inferences of causality of an individuals behavior and the fundamental attribution error can be recognized on a general level and in more specific areas such as mental illness. For instance, "what" a person's behavior is attributed to is an important question when considering the behavior of someone who is labelled "mentally ill", and the consequences the label may have on other things such as reactions to, and treatment of, the individual. There are a number of ways or frameworks for understanding the attributions towards mental illness, all of which have, as the underlying theme, the notion of dimensions on which the attributions are made. Research has generally assumed there to be two dimensions, etiology of mental illness, and the treatment in terms of who takes control. The next section will discuss this research on the dimensionality underlying attributions to mental illness and also

compare the various approaches offered. Kept in mind throughout this section is the question, "What evidence is there to support the notion of two dimensions?"

PREVIOUS FRAMEWORKS FOR UNDERSTANDING THE DIMENSIONALITY OF ATTRIBUTIONS IN MENTAL ILLNESS

The Medical Model

The general philosophy which pervades many realms of the Western culture is that of a dualistic system. This may set boundaries for the perception of mental illness that are very different from other cultures. For instance, the split between body and mind is a very dominant theme throughout our beliefs about diseases and problems with the human body. Hence the view that physical disease is very different from mental disease that is predominantly held by Westerners. The two are seen as separate problems, which is reflected in the respective therapeutic methods applied to them. There is also the view that the mentally ill should not be viewed as deviant but rather as "sick", (Crocetti et al 1974). These two views are not in opposition; the latter is claiming that mental illness is a "disease" and that these people are sick rather than deviants that need to be controlled, and the former is saying that this disease is of the mind which is distinct from the body although it may still need treatment as such.

The notion that mental illness is a disease rather than deviant behavior is known as the medical model, to which psychiatrists tend to adhere as well as lay-persons. Basically this model assumes that: "a) Mental disorders are organic diseases; b) The visible evidence of the disorder is but a manifestation of an underlying substructure; c) The individual has no responsibility for his or her behavior; d) The best way to understand psychiatric symptoms is through diagnostic procedures,"

Blaney (1975). The assumption is that there is a disease process implying a no choice situation, alleviation of responsibility, plus the ability to be cured.

Researchers such as Crocetti et al (1974) state that the public views mental illness as a sickness and thus also holds a medical model position. Although they suggest this is a positive view to hold and one of acceptance by the public this interpretation has been questioned by Sarbin and Mancuso (1970), Rabkin (1972,1974), and Morrison (1980). Morrison proposes that the medical model encourages "radical 'medical' treatments, and fear of mental illness", (p.699) as well as fostering a stigma that is associated with the mentally ill. The fear may come from believing the mentally ill are dangerous and unpredictable due to loss of control from the "disease".

The benefits of the medical model stance obviously lie in not only reducing the responsibility the individual may feel for the "problem", but also by shifting the burden of alleviating the problem to professionals who can presumably treat and cure it like any other illness. Thus, the acceptance of mental illness lies in viewing it as a disease and needing treatment from others. This very notion is causing much debate as to whether it is a beneficial position to hold.

Morrison (1980) reports the medical model to be a possible hindrance to effective community psychology and favours attempts to change the public's conception of mental illness from that reflecting a medical model orientation to a psychosocial one. A psychosocial model encourages individuals to take some responsibility for their problem, at least with respect to taking a more active part in reducing the problem. He discusses the effects of demythologizing seminars on patients and helpers with regard to changing their attitudes by informing them that there are other ways of perceiving mental illness besides that of the medical model. He emphasizes the fact that people should be aware of these other conceptions so that the best model can be

adopted in treatment situations according to the problem.

The fact that the medical model is so widely held causes us to consider where the model is promulgated. The media, as well as practitioners and socializing agents all play a part in providing the public with information about mental problems. Moreover, the actual prescribing of drugs can also communicate medical model information. Thus, we become caught in a circle whereby the medical model adheres to the practice of prescribing medication and the latter actually communicates and reinforces this model.

The medical model as described above can be seen as presenting mental illness as an internal condition and a dispositional problem that requires treatment accordingly. The causal attributions made about mental illness demonstrated in this model may also reflect the fundamental attribution error in that environmental factors are not taken into account when making these attributional judgements. Johnson (1973) supports this very claim when suggesting that patients and many mental health professionals see the treatment of "psychological problems" within a medical model context. Moreover, in the attempt to get the public to view mental illness in the same way as physical illness, expectations and behaviors in the treatment setting have been adversely, rather than positively, affected. In particular, patients expect to "relate their symptoms and receive medicine or advice" (p.6 Johnson 1973) for physical complaints and then hold similar expectancies for mental health problems. Johnson proposes three reasons for this generalization; first, individuals have more experience with physicians and assume the same roles for mental health professionals, second, the black couch image portrays a passive role for the client, and third, the role of the media in presenting mental illness as a "disease".

Implied in the medical model are two independent dimensions; one concerning

the beliefs about the causes or etiology of mental illness, and a second one concerned with the designation of responsibility in the treatment situation. The medical model specifically states that the causes of mental illness are internal to the individual, that is, the person does not have control and is therefore not responsible for the problem. In addition, the individual needs help from external sources to cure the problem, that is, he/she is not responsible for the solution to it.

Brickman et al

Brickman, Rabinowitz, Karuza, Coates, Cohn and Kidder (1982) constructed a conceptual framework concerned with attributions of responsibility for the problem and the solution. (The theme of Brickman et al's work was the different form that peoples' behavior takes when they are either trying to help others or help themselves.) Underlying the framework was the assumption of two orthogonal dimensions, (as implied by the medical model); causes of mental illness and responsibility in treatment. The implications of this assumption lead Brickman et al to generate three "models", other than the medical model, based on whether the client has high or low responsibility for the cause of the problem, and high or low responsibility for the solution. The models are: medical model, moral model, enlightenment model, and the compensatory model.

Medical Model

Related to the earlier discussion on the medical model, individuals are not seen as responsible for the problems or the solutions and are thus believed to need treatment. However, in Brickman et al's definition of this model, situations and circumstances outside of the individual are included, as well as those internal to the person, as

factors that the individual may not be responsible for.

Moral Model

Individuals are held responsible for both problems and solutions and thus need proper motivation to deal with the problems.

Enlightenment Model

Individuals are responsible for the problems but are unable or unwilling to provide solutions and therefore need discipline.

Compensatory Model

Responsibility for the problem does not lie with the person but he/she is thought to be responsible for the solution and therefore needs power.

A study by Rabinowitz (1978) suggested that these models do exist and that it is appropriate to categorize helping methods in terms of attributions of responsibility. Rabinowitz interviewed respondents from four different groups who were expected to adhere to the ideology associated with one of the four models. The medical model was represented by students in a college infirmary, the moral model by Erhard Seminar Training (est), the enlightenment model by a national evangelical group called the Campus Crusade for Christ, and the compensatory model by a job training program under CETA (Comprehensive Education and Training Act).

The beliefs, assumptions, and expectations about the nature of help offered in

their particular group were assessed from twelve respondents from each organization. Findings were in accordance with the assumptions of each model and confirm the existance of these models.

However, there has been no direct test of the two theoretical dimensions underlying these models; to conclude that the dimensions exist is premature.

Hill and Bales

Hill and Bales (1980) also assumed there to be two independent dimensions when looking at the relationship between etiological beliefs of mental illness and locus of control expectancies in the treatment situation. They devised two scales to measure the dimensions. The scales were the Mental Health Locus Of Origin (MHLO) and the Mental Health Locus Of Control (MHLC).

Mental Health Locus Of Origin.

The etiological beliefs of mental health care recipients, not just those giving treatment, were the particular concern of Hill and Bales when they developed the MHLO. They went as far as to say that the lack of recognition of these beliefs may be why adequate care for mental illness is not available.

There has been limited research investigating etiological beliefs, and that which has been done, Hill and Bales pointed out, had various problems. Methodological problems such as how responses were assigned to categories hindered some studies as well as subject sample variation, preventing accurate generalization of results. Other studies focused on issues of general attitudes to mental illness and not primarily etiological beliefs. However, despite these problems, these

earlier studies did come up with at least one factor concerning organic causes and one factor concerning environmental causes.

Durkin et al (1964) had their main objective directed at etiological beliefs and reported that individuals who believed that patients were responsible for treatment success scored higher on the interactional etiological beliefs, stressing individual and social environment interaction. In a similar vein Cumming and Cumming (1957) found that individuals who saw causes of mental illness situated in the economic or social system considered themselves responsible for it whereas if the causes were perceived as biological then they did not have responsibility.

Eker (1985b) set out to examine the effects of four types of causative factors on judgements of mental illness, social distance and prognosis. The assumption was that certain causes (psychological, social, genetic, car accident) of paranoid schizophrenia will influence the perceived severity of mental illness and expectations about the outcome and this will also affect the degree of acceptance of the individual. Eker's findings indicated that more labels of mental illness were given and greater social distance expressed for organic conditions rather than psychological or social conditions. Psychosocial aspects of mental illness were also related to more optimistic prognosis.

Norman and Malla (1983) were also aware of how components of attitudes to mental illness (causes, effective treatment, prognosis and social distance) could affect peoples' reactions to it. The findings of this study, in agreement with Eker, showed that a belief in

psychosocial etiology and treatment rather than physical and medical treatment was positively related to the expectation of a good prognosis and social acceptance of the mentally ill. The reasons for these findings are not completely clear but it was suggested that psychosocial factors are seen as more flexible than medical ones and thus a more optimistic view of recovery will be held because external situations and conditions may be more easily changed, (as opposed to internal, stable ones).

It was Gilbert and Levinson (1956) however, who suggested that there was a "dimension" rather than separate factors that could be employed to measure attitudes to mental illness. This "custodial-humanitarianism" dimension, furthermore, had factors concerned with etiology that could be placed along it, for example, heredity and organicity (custodial pole), and interpersonal and intrapsychic sources (humanitarianism pole).

The MHLO employs an endogenous-interactional etiological dimension which can be seen as analogous to the above factors. The belief that mental illness is caused by something internal to the individual, e.g. a genetic condition, would be at the endogenous end of the scale. Likewise, if mental illness is thought to be due to circumstances external to the individual, then this would be at the interactional end.

Mental Health Locus Of Control

The MHLC scale measures an individuals beliefs concerning

where control lies in the treatment situation, either with the client or the helper. The development of the MHLC scale was due to two main reasons. First, there was a need for a more specific scale than Rotter's internal-external locus of control measure of generalized expectancies in the area of clinical and psychological adjustment (Rotter 1966). This was not least because of the importance of the "control" issue within this domain. Hill and Bales point out how in the area of psychotherapy, and one presumes in other areas of therapy and treatment situations, the therapists are supposed to "help" the clients because they are the experts. However, "the goal of therapy is for the clients to become more able to help themselves" (p.281). Therefore, there is a paradox of the therapist "helping" and thus being responsible for the change, or else not helping and thus producing no change. One can appreciate here how the expectancies of the client are crucial in that not only will they have a direct bearing on the relationship between the therapist and the client but they will also influence whether an individual seeks treatment, what type of treatment is sought, the course of the treatment, and finally the outcome in terms of satisfaction and good prognosis. These expectations are in terms of who is believed to have control, (locus of control), in the treatment situation, the therapist or the client.

The MHLC is based on the existence of an internal-external locus of control dimension. The belief that the individual should assume some control in the treatment setting falls at the internal end. Conversely, if control is placed in the hands of the therapist, then this

would reflect an external locus of control.

Hill and Bales found a correlation between the MHLO and the MHLC in a study using university students, (.4 $p<.001$), such that beliefs in endogenous causes correlated with external locus of control in the treatment situation and likewise for interactional beliefs and internal locus of control.

However, Hill and Bales have not carried out any factor analysis on their scales to determine whether the dimensions they supposedly reflect in fact exist. Instead, Hill and Bales assert that there are two dimensions from past research and observations and then proceed to devise two scales which are subsequently found to be correlated.

Karanci

Karanci (1986) based her work on the Transtheoretical Approach of Prochaska (1984) in a study on the causal attributions towards psychological illness among Turkish psychiatric in-patients. Karanci is mainly concerned with the issue of causes of mental illness, but does talk of the implications causal beliefs can have on peoples hope for future well-being. Thus, in agreement with Hill and Bales and Brickman et al, Karanci suggests that there is an etiological domain in which attributions towards mental illness are made. However, in contrast to the other three frameworks mentioned, Karanci talks about three higher-order factors within this domain which emerged from factor analysis of a thirty-one item questionnaire on the causal beliefs of mental illness. The three factors are; a) the individual is to blame, b) no-one is to blame, c) others are to blame. (Hill and Bales proposed one bipolar dimension concerned with etiology which had endogenous-interactional poles. The medical model,

similarly, implied there was a bipolar dimension with internal-external poles, and Brickman et al talked about a bipolar dimension with the individual being responsible versus not being responsible for the problem as the two poles.)

Prochaska was actually addressing the problem of deciding which type of therapy is best in terms of beliefs about the causes of mental illness. He suggested that mental health problems are attributed to five content areas, (factors emerging from a factor analysis), one of which is usually focused on by the therapist depending on his/her theoretical orientation. These five factors are: Symptom/Situational, Maladaptive Cognitions, Current Interpersonal Conflicts, Family/Systems Conflicts, Intrapersonal Conflicts. After two factor analysis, the original five factors were reduced to four due to the merging together of "family" and "interpersonal conflicts".

Karanci (1986) used a Turkish sample and found other content areas/factors that appear to be specific to this sample such as conflicts with the family of origin and conflicts with the present family. In a higher order analysis the seven factors, (interpersonal, present family, family of origin, fate and materialistic difficulties, personal characteristics blamed on others, lack of will power, personal symptoms), were grouped under three higher-order factors which Karanci labeled; self-familial domain, externalized blame, uncontrollable domain. Furthermore, in contrast to Prochaska's finding, Interpersonal and Family conflicts appeared as two separate factors under different higher-order factors. Interpersonal conflicts were seen as an area that the individual has no control over, along with fate and material difficulties, and lack of will power. In other words, the content areas could be categorized under one of the three dimensions: a) the individual is to blame and is responsible for the problem, (self-familial domain; present family, family of origin, personal symptoms), b) no-one is to blame, (uncontrollable domain; interpersonal, fate and materialistic difficulties, lack of

will power), and c) other people are to blame, (externalized blame; personal characteristics blamed on others), all of which are integral to the domain of etiology.

In summary, Karanci is talking about the domain of etiology, and provides data to suggest that there are three dimensions in this domain that explain the attributions towards mental illness. The three dimensions emerged from factor analysis of the factors, (content areas), which emerged from the original thirty-one item questionnaire. However, Karanci's findings are open to more than one interpretation. For instance, I propose that the three factors he derived can represent one bipolar dimension of etiology by collapsing the three factors into two; "individual to blame", "individual not to blame". In this way, the frameworks for understanding attributions towards mental illness by Karanci and Brickman et al are very similar, both proposing that attributions are made on the basis of who is to blame.

COMPARISON OF THE FRAMEWORKS TO UNDERSTAND DIMENSIONALITY

Hill and Bales talk about the same dimensions as implied by the medical model, and also define them similarly. That is, internal-external etiological beliefs and internal-external responsibility/control in the treatment situation. In fact, Hill and Bales specifically state that etiological beliefs can be "characterized as differing along a dimension between a 'medical model' pole, employing genetic and physiological factors and a pole focusing on the interactions between an individual and the social environment" (Hill and Bales 1980 p.148). In effect then, Hill and Bales are providing a measure of the medical model dimensions, and, as mentioned earlier, found a positive correlation between the two scales.

On first glance Hill and Bales look as if they are also talking about the same dimensions as Brickman et al, etiological beliefs and responsibility/control in treatment,

thus providing a measure for Brickman et al's framework. However, on closer examination, we find that the two approaches are not comparable. The reason for this lies with the fact that Brickman et al define both dimensions using the central concept of "responsibility". Hill and Bales, on the other hand, only use the responsibility concept in the treatment setting. Therefore, on the surface, Brickman et al's Medical Model looks as if it represents the endogenous-external correlation, (individual having no control/ responsibility), and the Moral Model, the interactional-internal correlation, (individual having control/responsibility). However, when looking at this in more detail we find that this is not the case. The Medical Model in Brickman et al's terms means the person is not responsible for the problem, regardless of whether the cause is genetic/physiological etc, (endogenous), or due to circumstances external to the person, (interactional). Thus, external conditions that the individual cannot control are also included in this interpretation of the medical model. Likewise, in Brickman et al's terms, the interactional pole can also represent the situations that the person feels he/she does have control over and is responsible for, and the endogenous pole can represent beliefs that one is responsible for the biological well-being of the person.

In short, Hill and Bales' dimension is based on the naive presumption of a "physical" and "social" distinction between what causes mental illness, and does not take into account who is believed to be "responsible" for the problem. Brickman et al, however, think that whether the person is responsible or not is the deciding factor in categorizing people's attributions of causality, not just where the cause is located.

Further evidence to support the notion of "responsibility" in attributions towards mental illness comes from Karanci's study. Karanci is concerned with the issue of etiological beliefs, and the aspect of locus of control and responsibility is very apparent in the dimensions he suggests, whether they are defined as a bipolar

dimension or not.

Furthermore, in examining the predictive power of these attributions, Karanci found that if individuals attributed the development of their disorder to the self-familial dimension (inner control), they were optimistic for the future as far as their health was concerned. Conversely, if the problem was attributed to the uncontrollable dimension, hope was decreased and a feeling of pessimism was more apparent. This could be related to the model of learned helplessness proposed by Seligman (1975) in which individuals who view events as uncontrollable feel hopeless and show little effort and motivation to change the situation and thus do not have much hope for the future. It is also more relevant to Brickman et al's framework rather than Hill and Bales in that there is a link between attributions of controllability of the problem and attributions towards treatment with respect to the "responsibility" that is assumed by the client. In short, individuals will have a passive or active role in the treatment setting depending on their feelings of "control" of the problem.

From the discussion above we can see that there is inconclusive research available concerning the nature and definition of the dimensions underlying attributions towards mental illness. The etiology dimension is recognized by Brickman et al and Hill and Bales, although they differ on the definition of this dimension. Karanci is concerned with the etiology domain and suggests that there are three dimensions within it. However, the three factors he derived can be collapsed into two in the view of the present author thus making a bipolar dimension like the other researchers'. A second bipolar dimension concerning the attributions of control in the treatment setting has also been assumed, (Brickman et al and Hill and Bales), or at least recognized as an implication of etiological beliefs, (Karanci).

The definitions of the dimensions vary in terms of whether "responsibility" is a

crucial element or not. Brickman et al and Karanci agree on the importance of "responsibility" for both dimensions whereas Hill and Bales only recognize it in the treatment dimension.

Neither Hill and Bales or Brickman et al provide any test of the theoretical dimensions they propose. Karanci carried out a factor analysis but firstly, the findings are open to more than one interpretation, and secondly, as Karanci is not directly concerned with the dimension of treatment responsibility he offers no empirical analysis in this area.

Therefore, in addition to the problem of lack of research in the field of dimensionality and attributions towards mental illness, there is also the problem of the variability in number, nature and definitions of these dimensions.

The present study aims to test some of the assumptions that are present in the literature reviewed here and hopefully shed some light on the conflicting ideas in the field of dimensionality and attributions towards mental illness.

There are two major issues that will be dealt with in the attempt to test the assumptions. The first one is to examine the very basis of the research discussed above, that is, what evidence is there for dimensionality underlying attributions towards mental illness. In short, is there an underlying structure to the area of attributions towards mental illness. If there are dimensions, the next question is how many dimensions are there. Thirdly, what is the nature of the dimensions, and how should they be defined.

A questionnaire is used to tap attributions to mental illness in a sample of providers and consumers of mental health services. Questions about the causes of mental illness and the treatment situation are represented on the questionnaire. A

factor analysis is carried out on the questions.

Karanci's and Prochaska's study, as we recall, differed with regard to the merging together of the "family" and the "interpersonal conflicts" content areas. In Karanci's Turkish sample these factors appeared as two separate causal factors. Kagitcibasi (1985) suggests that this is a reflection of the differences between the two cultures, particularly in terms of the family structure. Individualism, independence, and autonomy are stressed and valued in Western societies whereas in other cultures, for example Turkey, mutual reciprocity, dependence, and loyalty are more highly favored. Thus, Karanci (1986) hypothesized that it would be more likely that family conflicts and personal symptoms (intrapersonal conflicts) would merge for a Turkish sample, and not family and interpersonal conflicts which would be seen as two separate causes. This hypothesis was supported, and, as mentioned earlier, the interpersonal conflicts were seen as uncontrollable by the individual.

This observation highlights the fact that populations may vary cross-culturally with respect to the attributions they hold towards mental illness. Therefore, there may also be differences between sub-populations in the same culture. These differences may be due to SES, age, race, and other social variables.

With regard to this, a comparison of the providers and consumers with respect to their attributions will also be done to see if "dimensionality" is the same for different populations in society. Specifically, does a pattern emerge indicating that providers make attributions towards mental illness based on one criteria, for example, internal-external causes, and consumers on another, for example, whether mental illness is defined as a "serious" condition or not.

The second issue is concerned with the influence of demographic and social variables on the attributions of providers and consumers. It is quite possible that the

complex dimensionality of attributions towards mental illness is due implicitly to differences in sociodemographic variables and not merely based on the criteria of locus of control or responsibility.

A SUMMARY OF THE ANALYTICAL APPROACH TO THE TWO ISSUES

DIMENSIONALITY AND ATTRIBUTIONS

Providers and consumers analyzed together and as separate populations.

I. Factor analysis of the 17 questions produces two independent dimensions:

A) The dimensions reflect "etiology" and "treatment", supporting Hill and Bales, Brickman et al, and Karanci in their descriptions of the dimensions.

B) The dimensions do not reflect "etiology" and "treatment".

If A), then how are the dimensions of etiology and treatment defined?

1. ETIOLOGY

a) Two elements emerge:

(i) attributions of "internal causes" and attributions of "external causes", supporting Hill and Bales' definition.

(ii) attributions of "being responsible" and attributions of "not being responsible", supporting Brickman et al's and Karanci's definition.

b) More than two elements emerge. We should consider Karanci's original proposal of three factors.

2. TREATMENT

a) Two elements emerge:

(i) attributions of "internal locus of control" and attributions of "external locus of control", supporting Hill and Bales' and Brickman at al's definition.

b) More than two elements emerge. We need to consider an alternative definition of the treatment dimension.

Due to the small data set in this study, examination of the factor loadings of the variables could also help us to understand how the dimensions should be defined.

Assuming there are two dimensions of etiology and treatment, a significant correlation between the dimensions would suggest that Hill and Bales' framework may be appropriate, although the correlations of the dimensions would not tell us anything about the definitions of the dimensions. A non-significant correlation between the dimensions would suggest that Brickman et al's framework involving four alternatives is more appropriate. Again, we do not know whether the definitions that Brickman et al assign the alternatives are correct.

If I. B) (above), then we need to consider alternative definitions for the dimensions underlying attributions towards mental illness.

II. Factor analysis of the 17 questions produces more than two dimensions: speculation of an alternative framework is needed.

DEMOGRAPHIC VARIABLES AND ATTRIBUTIONS

Comparison of the Providers' and Consumers' attributions with respect to the influence of demographic and social variables on these attributions.

Chapter 3

Method

SAMPLE

The respondents were 108 providers and 134 consumers of mental health services from a seven county area consisting of Carbon, Monroe, Pike, Schuylkill, Northampton, Lehigh and Berks. The respondents had answered a survey that was being carried out for The Regional Task Force on Women's Mental Health. The Pennsylvania Task Force for Mental Health: Women, required the Regional Task Force to assess the mental health needs of women in a seven county area. The survey was developed to help in this assessment and had two forms, one each for the providers and consumers.

Providers

Out of 108 providers, 87% were female, 13% were male. The respondents ranged from 18–70 years old, 67% falling in the 31–45 year age bracket, 16% between 46 and 55 years old, 15% between 18 and 30 years old, and 2% in the 56–70 year age bracket.

The agencies and services were categorized into six groups:

a) counseling/rehabilitation/therapy (31%)

b) welfare (26%)

c) unspecified mental health agencies (19%)

d) medical/psychiatric (10%)

e) crime related (8%)

f) church/religious (6%)

Approximately 57% of the agencies were public, 42% were private. (For a

complete list of the agencies see Appendix 1.)

Occupations of the respondents were categorized into four groups:

a) counselor/therapist (40%)

b) supervisory (39%)

c) clinical/medical (13%)

d) educators and administrators (8%).

Just over 50% reported the qualifications they had for their position. 23% of these respondents each had either "specific training in their field", "experience in their field", or a "masters degree"; 18% had a "bachelors degree"; 5% had "medical training"; 3% each had a "PhD" or "administration and educational experience"; and 2% had been the "victim".

Approximately 50% of the providers had been employed in their particular field for 6–15 years, and 24% each for 1–5 years and 16–30 years.

The specific services and treatment that were offered by the agencies were varied and were categorized into five groups:

a) therapy/counseling (32%)

b) nonmedical assistance (eg. referrals, welfare assistance) (23%)

c) support/understanding (20%)

d) medical/psychiatric help (14%)

e) education (8%).

Consumers

The consumers were parents of children in classes from elementary, junior and senior high schools. To reach individuals without children various women's clubs in the seven counties were also used. A total of 134 consumers responded and were all female. Like the providers, consumers ranged from 18–70 years of age. Approximately 52% were between 31 and 45 years old, 18% between 46 and 55, 17% in the 56–70 year

age bracket, and 13% between 18 and 30 years old. The majority, 72%, of the respondents were married, 8% each were single, divorced, or widowed, and 5% were separated.

Occupations of the consumers were categorized into six groups:

a) professional/technical (54%)
b) clerical/sales (18%)
c) housewife (15%)
d) retired (6%)
e) factory/service (5%)
f) student (2%).

Most of the consumers had never sought treatment before (80%), and of the 20% that had, 78% saw someone privately, 22% went to a public agency. Without distinguishing between private and public treatment, 35% of the consumers were each treated by a "psychologist or psychiatrist", 10% each saw a "social worker" or "counselor/therapist", and less than 5% each were treated by a "medical nurse", "mental health nurse" or "support groups". The type of treatment received varied, but, over half (55%) of those who had sought treatment received "individual therapy", 13% were given "drugs", 10% attended "support groups", 8% each received "psychotherapy" or "group therapy", and 3% were given a "sympathetic ear and understanding". Regardless of the type of treatment received, 32% of the respondents rated it as "excellent", 20% each said it was "good" or "fair", 16% said it was "not very good", and 12% thought it was "useless".

Many, 78%, of the total consumer respondents reported that they know or knew someone that suffers or had suffered from a mental health problem.

THE QUESTIONNAIRE AND PROCEDURE

The questionnaire came from the larger survey mentioned above. For the present study only part of each survey is used. Background information was obtained on demographic and social variables of both populations.

The section of the survey measuring attitudes and attributions towards mental illness is used, and represents the questionnaire that is refered to in this paper. (This is the same for providers and consumers.) Included in this section are items representing etiological beliefs about mental illness and beliefs about who takes control/responsibility in the treatment setting. Subjects responded to each item on a 5-point Likert scale.

The survey was mailed to each agency for the providers, and to each school and women's club for the consumers. They were asked to complete it and return by mail. (See Appendices 2 and 3 for complete surveys.)

Chapter 4

Results

DIMENSIONALITY AND ATTRIBUTIONS

The data from the questionnaire was subjected to a factor analysis using the SPSS(X) Principal Component Varimax rotated orthogonal analysis. (Questions 1, 4, 10, and 14 were disregarded throughout the analysis as they were felt not to be relevent to the topic of attributions in this study.) The only criterion that was established for inclusion of items under a factor was that they had a minimum loading of .40. Factor analyses were carried out on the data from the total population and the providers and consumers as separate groups.

FACTOR ANALYSES OF THE DATA FROM THE TOTAL POPULATION (N=242)

Six factors emerged which explained 58.3% of the variance. The six factor solution, the items under each factor and their loadings and per cent of variance explained by each factor are presented in Table 1.

Table 1: Factor matrix with loadings of 17 items on six factors (Total Population)

ITEMS	FACTORS 1	2	3	4	5	6
Factor 1: External causes of women's mental illness (18% of total variance)						
15. Women suffer from more mental health problems than men.	+.72	-.06	-.27	-.12	+.15	-.14
17. ... due to differences in the expected role behaviors of men and women.	+.85	+.09	+.02	-.01	-.08	-.01
23. ... due to society and it's pressures on women.	+.80	+.14	-.02	-.01	-.02	-.04

19.	... due to differences in the "personalities" of men and women.	-.52	+.03	+.24	-.03	-.01	-.24
25.	... due to traumatic experiences during childhood.	-.43	+.25	+.08	+.40	+.27	-.07

Factor 2: External causes (7.7% of total variance)

13.	Some mental health conditions are the product of a society with unreasonable expectations.	+.06	+.76	-.09	+.23	-.19	+.14
5.	Many mental health problems arise out of an inability to cope with life and it's stressful problems.	+.11	+.73	+.05	+.14	+.16	-.14

Factor 3: Medical Model (11% of total variance)

12.	Most serious mental illnesses are due to an imbalance of chemicals in the brain.	-.24	-.11	+.65	+.03	+.01	-.02
3.	Psychiatrists are the only people who can successfully treat mental illness.	-.02	-.01	+.71	+.18	-.02	-.18
6.	Medication is usually the most beneficial way to treat mental illness.	-.09	+.11	+.74	+.03	-.03	+.22

Factor 4: Pathology (8.8% of total variance)

8.	A person with a mental illness cannot successfully interact with other people.	-.15	-.12	-.02	+.68	+.11	+.17
2.	"Mental illness" refers to extreme states whereby a person cannot function properly in society.	+.13	+.01	+.16	+.55	-.07	-.31
7.	Most mental illnesses are passed down from generation to generation.	+.01	+.16	+.35	+.54	-.06	-.03

Factor 5: Treatment (6.2% of total variance)

21.	Women suffer from more mental health problems than men due to diagnostic procedures among mental health professionals.	-.21	-.02	+.06	+.06	+.79	+.33

11. Counseling or support groups are the most appropriate way of treating people with mental health problems.	+.35	-.01	-.01	+.04	+.62	+.35
Factor 6: Uninterpreted (6.6% of total variance)						
9. A diagnosis of mental illness is a subjective process based on expectations and preconceived ideas of the diagnostician.	-.02	-.01	-.01	-.03	-.10	+.78
Items not included in any factor						
16. Women suffer from <u>different</u> <u>types</u> of mental health problems than men.	+.09	+.38	+.22	-.36	+.38	+.09

The factors emerging from the factor analysis do not support Hill and Bales, and Brickman et al in their assumptions of two dimensions of etiology and treatment, but suggest that a more complex framework is needed to explain the dimensionality underlying attributions towards mental illness.

In order to examine the data in terms of Hill and Bales', and Brickman et al's assumptions, factor analyses were carried out forcing just three and two factors to emerge. The total variance explained by three factors was 37.8%. Table 2 portrays the three factor matrix.

<u>Table 2:</u> <u>Factor matrix with loadings of 17 items on three factors (Total Population)</u>

ITEMS	FACTORS 1	2	3
Factor 1: External causes of women's mental illness (18% of total variance)			
15. Women suffer from <u>more</u> mental health problems than men.	+.72	-.31	-.11
17. ... due to differences in the expected role behaviors of men and women.	+.81	-.05	+.14

23.	... due to society and it's pressures on women.	+.79	-.06	+.09
19.	... due to differences in the "personalities" of men and women.	+.48	-.26	-.13

Factor 2: Medical Model (11% of total variance)

12.	Most serious mental illnesses are due to an imbalance of chemicals in the brain.	-.31	+.49	+.11
7.	Most mental illnesses are passed down from generation to generation.	+.08	+.62	-.07
2.	"Mental illness" refers to extreme states whereby a person cannot function properly in society.	+.19	+.43	-.36
25.	Women suffer from more mental health problems than men due to traumatic experiences during childhood.	-.26	+.42	-.29
3.	Psychiatrists are the only people who can successfully treat mental illness.	-.06	+.64	+.01
6.	Medication is usually the most beneficial way to treat mental illness.	-.14	+.60	+.39

Factor 3: Diagnosis (8.8% of total variance)

16.	Women suffer from <u>different</u> <u>types</u> of mental health problems than men.	+.11	+.06	+.54
9.	A diagnosis of mental illness is a subjective process based on expectations and preconceived ideas of the diagnostician.	-.09	-.09	+.61
21.	Women suffer from more mental health problems than men due to diagnostic procedures among mental health professionals.	+.11	+.01	+.58

Items not included in any factor

11.	Counseling or support groups are the most appropriate way of treating people with mental health problems.	+.36	+.01	-.05
5.	Many mental health problems arise out of an inability to cope with life and it's stressful problems.	+.33	+.21	+.09

13.	Some mental health conditions are the product of a society with unreasonables expectations.	+.30	+.30	+.25
8.	A person with a mental illness cannot successfully interact with other people.	-.10	+.32	-.26

In terms of the six factor analysis, factor 1 is the same; "external causes of women's mental illness", factor 2 combines factors 3 and 4; "Medical Model" and "pathology", and factor 3 is interpreted as "diagnosis". Although items 13, 5, and 11 had loadings below .40 on factor 1, (.30, .33, .36 respectively), they did reinforce the interpretation of the factor of "external causes". Similarly, although item 8 had a loading below .40 on factor 2, (.32), it does reinforce the pathological view of mental illness that the Medical Model holds. The total variance explained by two factors was 29%, table 3 portrays the two factor matrix.

Table 3: Factor matrix with loadings of 17 items on two factors (Total Population)

ITEMS	FACTORS 1	2
Factor 1: External causes of women's mental illness (18% of total variance)		
15. Women suffer from more mental health problems than men.	+.58	-.47
17. ... dut to differences in the expected role behaviors of men and women.	+.79	-.20
23. ... due to society and it's pressures on women.	+.76	-.22
19. ... due to differences in the "personalities" of men and women.	+.45	+.34
13. Some mental health conditions are the product of a society with unreasonable expectations.	+.41	+.25

Factor 2: Medical Model
(11% of total variance)

12.	Most serious mental illnesses are due to an imbalance of chemicals in the brain.	-.17	+.56
7.	Most mental illnesses are passed down from generation to generation.	+.15	+.58
3.	Psychiatrists are the only people that can successfully treat mental illness.	+.05	+.64
6.	Medication is usually the most beneficial way to treat mental illness.	+.10	+.66
25.	Women suffer from more mental health problems than men due to traumatic experiences during childhood.	-.26	+.44

Items not included in any factor

5.	Many mental health problems arise out of an inability to cope with life and it's stressful problems.	+.37	+.15
11.	Counseling or support groups are the most appropriate way of treating people with mental health problems.	+.32	-.07
16.	Women suffer from <u>different</u> <u>types</u> of mental health problems than men.	+.30	+.09
21.	Women suffer from more mental health problems than men due to diagnostic procedures among mental health professionals.	+.29	+.05
9.	A diagnosis of mental illness is a subjective process based on expectations and preconceived ideas of the diagnostician.	+.10	-.01
2.	"Mental illness" refers to extreme states whereby a person cannot function properly in society.	+.13	+.35
8.	A person with a mental illness cannot successfully interact with other people.	-.12	+.31

Factor 1 is the same as for the six factor analysis (plus item 13, unreasonable expectations of society); "external causes of women's mental illness", factor 2 again combines the "Medical Model" and "pathology". Items 5, 11, and 21 also loaded on factor 1, and although their loadings were below .40 (.37, .32, .29 respectively), they did emphasize "external causes". Similarly, items 2 and 8 loaded below .40 on factor 2, (.35

and .31 respectively), but reinforce the pathological aspect of the Medical Model.

A summary of the three analyses for the total population is presented in Table 4.

Table 4:

SUMMARY OF FACTOR ANALYSES OF DATA FROM TOTAL POPULATION

Six Factors	% Total Variance	Three Factors	% Total Variance	Two Factors	% Total Variance
External causes of women's mental illness.	18.0%	External causes of women's mental illness.	18.0%	External causes of women's mental illness.	18.0%
External causes.	7.7%				
Medical Model.	11.0%	Medical Model.	11.0%	Medical Model	11.0%
Pathology.	8.8%				
Treatment.	6.2%	Diagnosis.	8.8%		
Uninterpreted.	6.6%				
Total	58.3%		37.8%		29.0%

FACTOR ANALYSES OF THE DATA FROM THE PROVIDERS (N=108)

Seven factors emerged explaining 69.2% of the variance. The seven factor solution, the items under each factor and their loadings and per cent of variance explained by each factor are presented in Table 5.

Table 5: Factor matrix with loadings of 17 items on seven factors (Providers)

ITEMS	FACTORS 1	2	3	4	5	6	7
Factor 1: External causes of women's mental illness (19.4% of total variance)							
15. Women suffer from more mental health problems than men.	+.73	-.06	+.05	-.15	-.19	+.26	-.13
17. ... due to differences in the expected role behaviors of men and women.	+.87	+.10	+.08	-.04	+.18	+.04	-.04
23. ... due to society and it's pressures on women.	+.86	-.04	+.03	-.01	+.23	-.03	+.05
8. A person with a mental illness cannot successfully interact with other people.	-.45	-.07	+.42	+.06	+.01	+.08	+.01
Factor 2: External causes (7.4% of total variance)							
5. Many mental health problems arise out of an inability to cope with life and it's stressful problems.	+.03	+.80	-.07	+.01	-.17	+.12	-.14
13. Some mental health conditions are the product of a society with unreasonable expectations.	+.01	+.78	+.21	+.01	+.23	-.10	+.12
Factor 3: Pathology (7.9% of total variance)							
7. Most mental illnesses are passed down from generation to generation.	+.03	+.19	+.72	+.39	-.11	-.03	-.12
2. "Mental illness" refers to extreme states whereby a person cannot function properly in society.	+.12	+.03	+.66	-.21	+.01	+.19	+.18

Factor 4: Medical Model
(11.8% of total variance)

16.	Women suffer from <u>different</u> <u>types</u> of mental health problems than men.	+.17	+.22	-.35	**+.48**	-.16	+.26	+.43
12.	Most serious mental illnesses are due to an imbalance of chemicals in the brain.	-.13	-.01	+.08	**+.77**	-.03	+.04	-.13
6.	Medication is usually the most beneficial way to treat mental illness.	-.08	-.03	+.03	**+.73**	+.17	-.23	+.29

Factor 5: Diagnosis
(9.9% of total variance)

25.	Women suffer from more mental health problems than men due to traumatic experiences during childhood.	-.37	+.01	+.24	+.31	**-.49**	-.15	+.36
21.	Women suffer from more mental health problems than men due to diagnostic procedures among mental health professionals.	+.20	+.01	+.09	-.02	**+.84**	-.13	+.09
9.	A diagnosis of mental illness is a subjective process based on expectations and preconceived ideas of the diagnostician.	-.09	-.02	-.19	+.42	**+.66**	+.29	-.06

Factor 6: Treatment
(6.2% of total variance)

19.	Women suffer from more mental health problems than men due to differences in the "personalities" of men and women.	-.45	-.12	+.08	+.04	-.04	**-.49**	+.25
11.	Counseling or support groups are the most appropriate way of treating people with mental health problems.	+.04	-.02	+.20	-.08	+.01	**+.85**	+.05

Factor 7: Uninterpreted
(6.6% of total variance)

3.	Psychiatrists are the only people who can successfully treat mental illness.	-.10	-.05	+.06	+.05	+.03	-.04	**+.86**

When the analysis forced just three factors to emerge the total variance explained was 41.1%. The three factor matrix is presented in Table 6.

Table 6: Factor matrix with loadings of 17 factors on three factors (Providers)

ITEMS	FACTORS 1	2	3
Factor 1: External causes of women's mental illness (19.4% of total variance)			
15. Women suffer from more mental health problems than men.	+.62	+.34	-.29
17. ... due to differences in the expected role behaviors of men and women.	+.81	+.28	+.03
23. ... due to society and it's pressures on women.	+.79	+.14	+.09
19. ... due to differences in the "personalities" of men and women.	-.56	-.24	+.12
25. ... due to traumatic experiences during childhood.	-.69	+.26	+.17
21. ... due to diagnostic procedures among mental health professionals.	+.48	-.24	+.39
8. A person with a mental illness cannot successfully interact with other people.	-.43	+.12	+.06
Factor 2: External causes (9.9% of total variance)			
2. "Mental illness" refers to extreme states whereby a person cannot function properly in society.	+.03	+.51	-.09
7. Most mental illnesses are passed down from generation to generation.	-.19	+.61	+.27
5. Many mental health problems arise out of an inability to cope with life and it's stressful problems.	+.02	+.48	-.01
13. Some mental health conditions are the product of a society with unreasonable expectations.	+.05	+.43	+.28
Factor 3: Medical Model (11.8% of total variance)			
16. Women suffer from different types of mental health problems than men.	+.06	+.16	+.48

12. Most serious mental illnesses are due to an imbalance of chemicals chemicals in the brain.	-.28	+.01	+.57
6. Medication is usually the most beneficial way to treat mental illness.	-.14	+.01	+.76
9. A diagnosis of mental illness is a subjective process based on expectations and preconceived ideas of the diagnostician.	+.26	-.31	+.60
Items not included in any factor			
11. Counseling or support groups are the most appropriate way of treating people with mental health problems.	+.18	+.36	-.07
3. Psychiatrists are the only people who can successfully treat mental illness.	-.24	+.05	+.36

In terms of the seven factor analysis, factor 1 is the same; "external causes of women's mental illness, factor 2 combines factors 2 and 3: "external causes" and "pathology", and factor 3 is the same; "Medical Model". Item 3 had a loading of below .40 on factor 3 (.36) but still emphasizes the "Medical Model" interpretation of the factor. The total variance explained by forcing two factors to emerge was 31.2%. Table 7 portrays the two factor matrix.

Table 7: Factor matrix with loadings of 17 items on two factors (Providers)

ITEMS	FACTORS 1	2
Factor 1: External causes of women's mental illness (19.4% of total variance)		
15. Women suffer from more mental health problems than men.	+.69	-.20
17. ... due to differences in the expected role behaviors of men and women.	+.84	+.11
23. ... due to society and it's pressures on women.	+.79	+.16
19. ... due to differences in the "personalities" of men and women.	-.60	+.05
25. ... due to traumatic experiences during childhood.	-.65	+.16

8.	A person with a mental illness cannot successfully interact with other people.	-.41	+.05

Factor 2: Medical Model (11.8% of total variance)

16.	Women suffer from <u>different</u> <u>types</u> of mental health problems than men.	+.05	+.50
12.	Most serious mental illnesses are due to an imbalance of chemicals in the brain.	-.32	+.55
6.	Medication is usually the most benefical way to treat mental illness.	-.20	+.74
9.	A diagnosis of mental illness is a subjective process based on expectations and preconceived ideas of the diagnostician.	+.15	+.57

Items not included in any factor

21.	Women suffer from more mental health problems than men due to diagnostic procedures among mental health professionals.	+.39	+.39
11.	Counseling or support groups are the most appropriate way of treating people with mental health problems.	+.25	-.02
2.	"Mental illness" refers to extreme states whereby a person cannot function properly in society.	+.13	-.03
5.	Many mental health problems arise out of an inabiltiy to cope with life and it's stressful problems.	+.11	+.05
3.	Psychiatrists are the only people who can successfully treat mental illness.	+.25	+.34
7.	Most mental illnesses are passed down from generation to generation.	-.10	+.33
13.	Some mental health conditions are the product of a society with unreasonable expectations.	+.10	+.33

Factors 1 and 2 are the same as for the seven factor analysis; "external causes of women's mental illness" and "Medical Model". Items 3 and 7 loaded below .40 on factor 2 (.34 and .33 respectively) but again add more weight to the "Medical Model" interpretation I give to the factor.

A summary of the three analyses for the Providers is presented in Table 8.

Table 8:

SUMMARY OF FACTOR ANALYSES OF DATA FROM THE PROVIDERS

Seven Factors	% Total Variance	Three Factors	% Total Variance	Two Factors	% Total Variance
External causes of women's mental illness.	19.4%	External causes of women's mental illness.	19.4%	External causes of women's mental illness.	19.4%
External causes.	7.4%	External causes.	9.9%		
Pathology.	7.9%				
Medical Model.	11.8%	Medical Model.	11.8%	Medical Model.	11.8%
Diagnosis.	9.9%				
Treatment.	6.2%				
Uninterpreted.	6.6%				
Total	69.2%		41.1%		31.2%

FACTOR ANALYSES OF THE DATA FROM THE CONSUMERS (N=134)

Seven factors emerged explaining 65.4% of the variance. Table 9 presents the seven factor solution.

Table 9: Factor matrix with loadings of 17 items on seven factors (Consumers)

ITEMS	FACTORS 1	2	3	4	5	6	7
Factor 1: External causes of women's mental illness (16.8% of total variance)							
15. Women suffer from more mental health problems than men.	+.80	+.07	-.08	-.25	+.06	-.11	-.15
17. ... due to differences in the expected role behaviors of men and women.	+.81	+.06	+.01	+.06	-.01	+.14	+.21
23. ... due to society and it's pressures on women.	+.64	+.34	+.01	-.05	-.33	+.05	+.37
19. ... due to differences in the "personalities" of men and women.	-.41	+.07	-.13	+.21	-.31	-.41	-.01
Factor 2: External causes (8.7% of total variance)							
5. Many mental health problems arise out of an inability to cope with life and it's stressful problems.	+.28	+.62	-.17	+.24	+.11	-.40	-.09
13. Some mental health conditions are the product of a society with unreasonable expectations.	+.07	+.77	+.08	-.09	+.01	+.17	+.13
Factor 3: Pathology (8.2% of total variance)							
2. "Mental illness" refers to extreme states whereby a person cannot function properly in society.	+.04	+.05	+.48	+.38	-.11	-.12	-.41
8. A person with a mental illness cannot successfully interact with other people.	+.15	-.17	+.73	+.06	+.18	+.02	+.10
25. Women suffer from more mental health problems than men due to traumatic experiences during childhood.	-.33	+.35	+.61	-.04	-.06	-.08	-.06

Factor 4: Medical Model
(11.9% of total variance)

12. Most serious mental illnesses are due to an imbalance of chemicals in the brain.	-.20	-.33	+.02	**+.62**	-.19	-.09	+.13
3. Psychiatrists are the only people who can successfully treat mental illness.	+.10	-.01	+.10	**+.79**	-.04	-.09	-.12
6. Medication is usually the most beneficial way to treat mental illness.	-.20	+.19	-.07	**+.70**	+.07	+.16	+.07

Factor 5: Uninterpreted
(7.5% of total variance)

16. Women suffer from <u>different</u> <u>types</u> of mental health problems than men.	+.06	+.34	-.37	+.09	**+.41**	+.17	+.04
9. A diagnosis of mental illness is a subjective process based on expectations and preconceived ideas of the diagnostician.	-.05	+.03	+.09	-.11	**+.86**	+.01	+.04

Factor 6: Uninterpreted
(6.4% of total variance)

21. Women suffer from more mental health problems than men due to diagnostic procedures among mental health professionals.	+.11	+.08	-.21	+.01	+.09	**+.75**	-.17
7. Most mental illnesses are passed down from generation to generation.	-.14	+.11	+.34	+.40	-.21	**+.45**	+.04

Factor 7: Uninterpreted
(5.9% of total variance)

11. Counseling or support groups are the most appropriate way of treating people with mental health problems.	+.15	+.08	+.03	+.05	+.04	-.17	**+.86**

In forcing three factor to emerge the total variance explained was reduced to 37.4%. The three factor matrix is presented in Table 10.

Table 10: Factor matrix with loadings of 17 items on three factors (Consumers)

ITEMS	FACTORS 1	2	3
Factor 1: External causes (16.8% of total variance)			
15. Women suffer from more mental health problems than men.	+.63	-.43	+.01
17. ... due to differences in the expected role behaviors of men and women.	+.78	-.12	+.03
23. ... due to society and it's pressures on women.	+.83	-.05	-.03
5. Many mental health problems arise out of an inability to cope with life and it's stressful problems.	+.42	+.22	+.32
11. Counseling or support groups are the most appropriate way of treating people with mental health problems.	+.44	+.02	-.12
Factor 2: Medical Model (11.9% of total variance)			
2. "Mental illness" refers to extreme states whereby a person cannot function properly in society.	+.01	+.48	-.24
7. Most mental illnesses are passed down from generation to generation.	+.01	+.55	+.02
12. Most serious mental illnesses are due to an imbalance of chemicals in the brain.	-.16	+.56	-.28
3. Psychiatrists are the only people who can successfully treat mental illness.	+.12	+.71	-.04
6. Medication is usually the most beneficial way to treat mental illness.	-.05	+.68	+.31
Factor 3: Diagnosis (8.7% of total variance)			
16. Women suffer from different types of mental health problems than men.	+.10	-.03	+.65
21. Women suffer from more mental health problems than men due to diagnostic procedures among mental health professionals.	+.01	-.06	+.53
9. A diagnosis of mental illness is a subjective process based on expectations and preconceived ideas of the diagnostician.	-.16	-.23	+.41

13. Some mental health conditions are the product of a society with unreasonable expectations.	+.37	+.12	+.44

Items not included in any factor

19. Women suffer from more mental health problems than men due to differences in the "personalities" of men and women.	-.25	+.33	-.20
25. Women suffer from more mental health problems than men due to traumatic experiences during childhood.	-.11	+.30	-.14
8. A person with a mental illness cannot successfully interact with other people.	+.13	+.12	-.35

In terms of the seven factor analysis, factor 1 combined factors 1 and 2; "external causes of women's mental illness" and "external causes", factor 2 combines factors 3 and 4; "pathology" and "Medical Model", and factor 3 combines the two diagnosis factors. Items 19 and 25 loaded below .40 on factor 2 (.33 and .30 respectively) but again offer support for the interpretation of the "Medical Model" factor. The total variance explained by two factors was 28.7%. Table 11 portrays the two factor matrix.

Table 11: Factor matrix with loadings of 17 items on two factors (Consumers)

ITEMS	FACTORS 1	2
Factor 1: External causes (16.8% of total variance)		
15. Women suffer from more mental health problems than men.	+.62	-.39
17. ... due to differences in the expected role behaviors of men and women.	+.77	-.07
23. ... due to society and it's pressures on women.	+.80	-.01
5. Many mental health problems arise out of an inability to cope with life and it's stressful problems.	+.48	+.19

13.	Some mental health conditions are the product of a society with unreasonable expectations.	+.47	+.06
11.	Counseling or support groups are the most appropriate way of treating people with mental health problems.	+.40	+.06

Factor 2: Medical Model (11.9% of total variance)

2.	"Mental illness" refers to extreme states whereby a person cannot function properly in society.	-.05	+.52
7.	Most mental illnesses are passed down from generation to generation.	+.01	+.54
12.	Most serious mental illnesses are due to an imbalance of chemicals in the brain.	-.24	+.59
3.	Psychiatrists are the only people that can successfully treat mental illness.	+.10	+.71
6.	Medication is usually the most beneficial way to treat mental illness.	+.02	+.62

Items not included in any factor

16.	Women suffer from <u>different</u> <u>types</u> of mental health problems than men.	+.26	-.14
21.	Women suffer from more mental health problems than men due to diagnostic procedures among mental health professionals.	+.15	-.15
19.	Women suffer from more mental health problems than men due to differences in the "personalities" of men and women.	-.30	+.34
9.	A diagnosis of mental illness is a subjective process based on expectations and preconceived ideas of the diagnostician.	-.05	-.31
25.	Women suffer from more mental health problems than men due to traumatic experiences during childhood.	-.15	+.31
8.	A person with a mental illness cannot successfully interact with other people.	+.04	+.19

Factor 1 combines factor 1 and 2 from the seven factor analysis; "external causes of women's mental illness" and "external causes", factor 2 combines factors 3 and 4; "pathology" and "Medical Model". Items 19, 9, and 25 loaded below .40 on factor 2

(.34, -.31, .31 respectively) reinforcing the "Medical Model" interpretation.

A summary of the three analyses for the Consumers is presented in Table 12.

Table 12:

SUMMARY OF FACTOR ANALYSES OF DATA FROM THE CONSUMERS

Seven Factors	% Total Variance	Three Factors	% Total Variance	Two Factors	% Total Variance
External causes of women's mental illness.	16.8%	External causes.	16.8%	External causes.	16.8%
External causes.	8.7%				
Pathology.	8.2%	Medical Model.	11.9%	Medical Model.	11.9%
Medical Model.	11.9%				
Uninterpreted.	7.5%	Diagnosis.	8.7%		
Uninterpreted.	6.4%				
Uninterpreted.	5.9%				
Total	65.4%		37.4%		28.7%

DEMOGRAPHIC VARIABLES AND ATTRIBUTIONS

In order to examine the effect of demographic and social variables on the attributions, scales were compiled from the three factors (forced) for the providers and the consumers. Each person's score on each item was weighted according to that item's loading on the factor. The mean of these scores was then computed for each factor. Thus, each person had a mean score for each factor/scale. A one-way multiple comparisons analysis of variance was then performed on the scale scores and each demographic variable for the providers (age, agency, type of agency, occupation, qualifications, years employed, and services/treatment offered), and the consumers (age, marital status, occupation, whether they have ever sought treatment, type of agency visited, treated by, sort of treatment, rating of treatment, where they would go if suffering from a mental health problem, and whether they know anyone suffering from a mental health problem).

The analysis on the providers revealed only two significant results; occupation and qualifications by scale 3 ("Medical Model"). Eight significant results were found on the consumers analysis; age, whether the person has sought treatment before, type of agency visited, treated by, and sort of treatment by scale 1 ("external causes"), age and whether the person knew anyone suffering from a mental illness by scale 2 ("Medical Model"), whether the person has sought treatment before by scale 3 ("diagnosis").

The significant results from the analysis of variance for all three scales are presented in Table 13 and 14 for the providers and consumers respectively. (The means for all variables on all three scales for both populations may be found in Appendix 4).

Table 13: Significant results from analysis of variance of demographic variables and scale scores for the providers

Scale 3 (Medical Model)

Source		DF	MS	F	P
Between Groups:					
Occupation.		3	7.7986	2.7368	<.05
Error:		87	2.8495		
Means for each group:	Supervisory		8.8816		
	Clinical/Medical		7.4842		
	Counselor/therapist		8.1329		
	Educator/administrator		8.9700		
Between Groups:					
Qualifications.		7	7.1603	2.6948	<.01
Error:		77	2.6571		
Means for each group:	Degree		8.8053		
	MA		8.6000		
	PhD		10.1900		
	Medical training		7.1450		
	Specific occupation training		7.7959		
	Experience in field		9.1050		
	Administation/education		7.6300		
	Victim		4.8200		

Table 14: Significant results from analysis of variance of demographic variables and scale scores for the consumers on all three scales

Scale 1 (External causes)

Source		DF	MS	F	P
Between Groups:					
Age.		3	12.6865	2.8197	<.05
Error:		114	4.4992		
Means for each group:	18-30 years old		11.4767		
	31-45 years old		11.1690		
	46-55 years old		12.4095 *		
	56-70 years old		10.5665 *		

* Significant difference between the groups at .05 level using Tukey-B procedure.

Between Groups:					
Ever sought treatment before.		1	42.0588	9.1992	<.01
Error:		129	4.5720		
Means for each group:	Yes		12.4556		
	No		11.0137		
Between Groups:					
Type of agency visited.		1	21.4405	7.3144	<.01
Error:		21	2.9313		
Means for each group:	Private		12.7928		
	Public		10.4520		
Between Groups:					
Treated by.		6	8.0542	3.1907	<.05
Error:		18	2.5242		
Means for each group:	Psychologist		12.5455 $*^2$		
	Psychiatrist		12.3375 $*^2$		
	Social Worker		8.6500 $*^1$		
	Medical Nurse		15.0800		
	Mental Health Nurse		12.6300		
	Support Groups		14.1800		
	Counselor/therapist		15.5000		

$*^1$ significantly different from $*^2$ at .05 level using Tukey-B procedure.

Source		DF	MS	F	P
Between Groups:					
Sort of treatment received.		4	8.5189	2.8546	<.05
Error:		20	2.9843		
Means for each group:	Psychotherapy		12.1167		
	Group therapy		9.0800		
	Individual therapy		12.7744		
	Drugs		12.3300		
	Understanding		15.5000		

Scale 2 (Medical Model)

Source		DF	MS	F	P
Between Groups:					
Age.		3	12.3873	2.9644	<.05
Error:		114	4.1787		
Means for each group:	18-30 years old		10.0340		
	31-45 years old		11.4329		
	46-55 years old		11.6681		
	56-70 years old		10.5220		
Between groups:					
Know anyone suffering from mental illness.		1	32.6959	8.4271	<.01
Error:		128	3.8798		
Means for each group:	Yes		11.3726		
	No		10.1679		

Scale 3 (Diagnosis)

Source		DF	MS	F	P
Between Groups:					
Ever sought treatment before.		1	5.4192	3.7573	<.05
Error:		129	1.4423		
Means for each group:	Yes		7.3340		
	No		6.8164		

In order to compare the providers and consumers with respect to their responses on the factors or scales that were the same for both populations, a t-test was carried out on scale 2 ("external causes") and scale 3 ("Medical Model") of the forced three factor analysis. Significant results were found for both scales, ($t=42.55$, 240 df, $p<.001$) and ($t=25.01$, 240 df, $p<.001$) for scale 2 and scale 3 respectively. (See Appendix 5 for t-test calculations.)

Chapter 5

Discussion

DIMENSIONALITY AND ATTRIBUTIONS

The first issue of concern in the present study was to investigate the assumptions of past research on the dimensionality underlying attributions towards mental illness. Implicit to the concept of dimensions is the notion of how many there are, the nature of them, and the definitions given to them.

Total Population

The results showed that six factors emerged from a factor analysis of the data from the total population accounting for 58.3% of the total variance. The factors were labeled; "external causes of women's mental illness", "external causes", "Medical Model", "pathology", "treatment" and an uninterpretable factor of just one item. These factors on the surface do not support Hill and Bales or Brickman et al in their notion of two dimensions of "etiology" and "treatment". However, on closer examination there are some similarities that should not be ignored.

There does seem to be a distinction between etiology and treatment in terms of factors 1 and 2 and factor 5. Factors 1 and 2 only reflect items concerned with external causes, although if we look at items dealing with internal causes we see that they load under factor 3, "Medical Model" which also includes treatment items. Therefore, although it may seem as if etiology and treatment are different dimensions along which people make attributions towards mental illness, in my sample the factor of etiology does not include external and internal causes but rather reflects only externality.

Similarly, the factor interpreted as the "Medical Model" reflects internality. Although as mentioned above, there is a treatment factor, not all treatment items are included under this. Specifically, medically oriented treatment methods are included under the "Medical Model" factor. Thus, the distinction between causes and treatment of mental illness is not as obvious as it may first appear.

It is presumptuous, however, to conclude that Hill and Bales, and Brickman et al are incorrect in their assumptions of two dimensions. We can say however, that in this particular sample an alternative framework needs to be considered.

In order to examine the data in terms of Hill and Bales' and Brickman et al's assumptions, another factor analysis was carried out forcing just three factors to emerge. These three factors were labeled; "external causes of women's mental illness", "Medical Model", and "diagnosis". Once again the questions pertaining to women loaded on factor 1. In addition, items concerned with counseling and support groups, and an inability to cope with stressful problems in life (questions 11 and 5 respectively) loaded on this factor. Although their loadings were below .40 they do highlight external causes and add the element of treatment in this "causal" factor.

Factor 2 combined "pathology" and "Medical Model" and really served to reinforce the perception of mental illness as a "disease" and thus the appropriate treatment as medical. Furthermore, item 8 stating that a person with a mental illness cannot interact with other people also loaded on this factor (.32), and adds even more weight to this notion.

Factor 3 was labeled "diagnosis" and was a combination of factors 5 and 6 ("treatment" and "uninterpreted"). Implied in two out of the three items loading on this factor is the notion of causality with special consideration being given to the diagnosis of mental illness. In other words, the reason for the mentally ill label to be

given to someone is seen as a separate dimension on which people make attributions towards mental illness. More specifically, we may think of the "diagnostic" factor as not being on the same level as the attributional analysis of the other factors. It seems as if people are aware that an attributional process is going on and that by very definition it is a subjective process. Therefore attributions towards mental illness are not just made on the assumption of "reality" in terms of "what causes mental illness" but also take into account that the whole idea surrounding these attributions is that of a subjective process, that is, a diagnostic label. This is interesting in terms of attributions not being made solely according to etiology and treatment issues but more in terms of external causes, internal causes, and mental illness as a diagnostic label that is necessarily subjective.

In summarizing the results from the total population I have suggested that an alternative framework is needed and if I had a stronger data set then this hypothesis would probably be strengthened. The factors on the forced factor analyses were not based solely on treatment and etiology but rather <u>included</u> treatment and etiology items within each factor. Instead of referring to factor 2 as the "Medical Model" (taken from the use in the disease model of physical illness), it could be called "internal causes and medical treatment". Similarly, the interpretation of factor 1 was reinforced by treatment items and this may be reflecting an "external causes and non-medical treatment" factor. Factor 3 also leads us to consider that "etiology" may be broken down into more specific issues dealing with the "causes of the label or diagnosis of mental illness" which form a factor on their own.

The analysis and comparison of the providers and consumers of mental health services with respect to their attributions revealed some interesting differences.

Providers

The results showed that seven factors emerged from a factor analysis of the providers' responses accounting for 69.2% of the total variance. The factors were labeled; "external causes of women's mental illness", "external causes", "pathology", "Medical Model", "diagnosis", "treatment", and an uninterpretable factor of just one item. These factors are the same as those from the results from the total population, with the added factor of "diagnosis". As mentioned earlier, "diagnosis" may be a sub-group of the causality of mental illness, such that people make attributions towards mental illness on the basis of external causes, internal causes, and the diagnostic label given to the person.

With regard to Hill and Bales' and Brickman et al's assumptions of a causality and treatment dimension, the providers present a picture similar to that of the total population, that is, there is factor of "treatment" but not all treatment items load on it. The question concerned with medication loads on factor 4, "Medical Model", and the question referring to psychiatry as the best form of treatment forms a factor on it's own, factor 7. Although there are very few treatment questions in the data set they certainly do not appear to form a factor solely concerned with treatment. Also, the causality factor is just referring to "external" causes. Thus, these findings again call for consideration of another framework for understanding dimensionality.

When three factors were forced, the interpretations above were supported. The three factors were labeled; "external causes of women's mental illness", "external causes", and "Medical Model". Factor 2, "external causes", which combined "external causes" and "pathology" from the previous factor analysis is of special interest. Factor 2 included items 2 and 7 referring to mental illness as an extreme state and a hereditary condition, and also items 5 and 13 stating that mental illness arises out of not being able

to cope with life and it's stressful problems, and being a product of a society with unreasonable unreasonable expectations. This seems to imply that the inability to cope leads to an extreme condition for the person whereby he/she cannot function successfully in society. This condition may be passed down from generation to generation not through genetics but through socialization.

The question referring to mental illness being passed from generation to generation was intended in terms of genetical inheritence and generally I think it has been answered as such as it loaded on the "Medical Model" factor. However, it could be interpreted as referring to social inheritence which would make more sense loading on the factor of "external causes" as for the providers. The assumption is that providers of mental health services would be more aware of mental illness being able to pass from generation to generation in ways other than genetic. Furthermore, item 11 loaded on factor 2 (.36), suggesting that counseling may be a way to help people with a mental health problem and perhaps help prevent it from being passed down to children of individuals with a mental illness.

In factor 2 we can see even more how attributions are being made not on the criteria of etiology or treatment but according to the cause, how mental illness is defined, and what the appropriate treatment is.

In summary of the providers results, on a general level we can see how they are similar to the total population in terms of whether attributions are made using the criteria of etiology and treatment. The indication is that causality may be external, internal, or related to the diagnostic label. Also, in this specific sample there may be external causes which can be passed down from generation to generation. Not only does this imply that providers may use a more complex system of beliefs in making attributions towards mental illness, but also that the attributions include etiology and

treatment items which present a whole picture of mental illness from causes to diagnosis to treatment.

Consumers

Seven factors emerged from a factor analysis of the consumers' data which accounted for 65.4% of the total variance. The first four factors were labeled the same in all three analyses (total population, providers, consumers); "external causes of women's mental illness", "external causes", "pathology", "Medical Model". The last three factors were labeled uninterpretable for two reasons. First, out of five items two of them (16 and 7) loaded .40 or just below on other factors. In fact they make more sense loading on these factors. The second reason is that two of the factors had two items on them and the other factor only had one. This meant that it was very difficult to find a common denominator that the factors represented.

Only four factors were labeled in the consumers analysis and thus they do not demonstrate the same pattern as the providers and the total population in terms of a treatment and diagnosis factor. However, the "Medical Model" does include treatment items on it.

In the factor analysis forcing three factors the consumers resembled the total population more so than the providers did. The three factors were labeled; "external causes", "Medical Model", and "diagnosis". Factor 1 combined "external causes of women's mental illness" and "external causes" which suggests that in my sample, consumers do not make a distinction between causes of mental illness in general and for women specifically. Regarding etiology and treatment items, both appear on factors 1 and 2 supporting the suggestion made previously about dimensions dealing with both causes and treatment using the criteria of external or internal cause and the appropriate

treatment.

Factor 3 for the consumers was interpreted as "diagnosis" and again represents the notion of attributions being made on the basis of how the diagnostic label is assigned. This was an interesting finding as a "diagnosis" factor did not emerge in the previous analysis for the consumers.

The consumers', providers', and total populations' data was also factor analyzed forcing just two factors to emerge. The factors were labeled; "external causes of women's mental illness" and "Medical Model" (providers and total population) and "external causes" and "Medical Model" (consumers). Although there were approximately seven items that did not load on either factor there were some that loaded below .40 which reinforced the interpretation of the particular factor. By including these items the concept of treatment and etiology is apparent in each factor. However, only approximately 30% of the total variance was accounted for by the 2 factor analysis and thus we should be wary of placing to much emphasis on these findings.

The initial picture we get from the factor analyses of the total population, providers and consumers is that Hill and Bales' and Brickman et al's assumptions of two dimensons of etiology and treatment are not supported. The analyses produced at least six factors, four of which were labeled the same for all populations. These were; "external causes of women's mental illness", "external causes", "Medical Model", and "pathology". Furthermore, the results suggest that etiology and treatment are not necessarily separate dimensions. However, although Hill and Bales' scales are concerned with etiology (MHLO) and treatment (MHLC) they did find a correlation between the scales stating that a belief on one scale correlated with a particular belief on the other scale. In the present study I do not have separate scales for etiology and treatment and

therefore do not have correlations between them but items under a "factor", by definition, should correlate with each other. Thus, the observation of etiology and treatment items loading together under one factor implies that they correlate with each other. Specifically, external causes of mental illness loaded with treatment items concerned with support groups and counseling which can be interpreted as "self-help" forms of treatment, and internal causes of mental illness loaded with psychiatric and more "medical" forms of treatment. In short, etiology and treatment correlate with each other based on whether the treatment matches the causal belief, and so in this sense Hill and Bales' assumptions about dimensionality are supported.

It is more difficult to translate these findings into Brickman et al's framework as both "being responsible for the problem" and "not being responsible for the problem" can mean "external causes" but the aspect of responsibility cannot be separated out from this factor in my study. Therefore, the very nature of my data set implies that there is not enough evidence available to support or reject Brickman et al. It would be interesting to see what would happen if more questions specifically concerned with the notion of responsibility were included.

In summary, the results for my sample in this study suggest that;

1. Causal factors are based on external or internal etiology beliefs.
2. Treatment items also load on these factors according to which type of treatment matches the cause, offering support for Hill and Bales' finding of a correlation between the etiology (MHLO) and treatment (MHLC) scales.
3. A factor of "diagnosis" implys that causality may be broken down into specific issues concerned with how the label of mental illness is assigned.

Thus, although the assumption of two dimensions is not supported, some of the ideas implicit to the assumption are apparent, for instance, the relationship between

etiology and treatment. We can postulate therefore, that a more complex framework of more than two dimensions incorporating these ideas, is the most appropriate way of representing attributions towards mental illness.

However, caution should be taken in accepting these proposed interpretations as there were only 17 original questions in the analyses and six or seven factors emerged accounting for 58 to 70% of the total variance. When three factors were forced the variance accounted for was reduced to 37 to 41%. Another drawback was that there were more questions dealing with causes than treatment which means that the factors emerging were bound to be biased toward causality factors. Perhaps with more questions on treatment we would be able to come to clearer conclusions as to what exactly the criteria are for making attributions towards mental illness.

A Comparison of Providers and Consumers

A comparison of the providers and consumers in terms of the factors that emerged brought to light the fact that these two populations are different with regard to the attributions they make although they use a similar framework for making them. (See Table 15 for a summary of factor analyses for all three populations.) Significant differences were found between the mean responses of providers and consumers on "external causes" and "Medical Model", indicating that providers were less likely to agree with the Medical Model orientation than the consumers but also less likely to agree with the extreme external causal orientation. These findings seem to contradict each other as they also imply that the consumers tend to agree with external causes and the Medical Model orientations. A possible explanation for these findings is that providers of mental health services are more reserved in their beliefs because they understand that mental illness need not be caused by either "medical" or "external"

Total Population		Providers		Consumers	
Six Factors	Three Factors	Six Factors	Three factors	Six Factors	Three factors
External causes of women's mental illness.	External causes of women's mental illness.	External causes of women's mental illness.	External causes of women's mental illness.	External causes of women's mental illness.	
External causes.		External causes.	External causes.	External causes.	External causes.
Medical Model.	Medical Model.	Pathology.		Pathology.	Medical Model.
Pathology.		Medical Model.	Medical Model.	Medical Model.	
Treatment.	Diagnosis.	Diagnosis.		Uninterpreted.	Diagnosis.
Uninterpreted.		Treatment.		Uninterpreted.	

Table 15: SUMMARY TABLE COMPARING FACTOR ANALYSES OF DATA FROM TOTAL POPULATION, PROVIDERS, AND CONSUMERS

factors individually. The consumers though, express more extreme beliefs because they are less informed about the causes of mental illness and therefore are more likely to agree with any suggestions of possible causes.

Providers and Consumers were also compared on the actual items loading on the factors to see in more detail the issues that they hold different beliefs on. The first difference refers to item 8 (unable to interact with other people), which loaded negatively on factor 1 ("external causes of women's mental illness"), for the providers, and positively on factor 3 ("pathology"), for the consumers. This may be explained by the very nature of the providers sample, that is, they are more likely to be aware that mental illness need not be socially dysfunctional to the person.

In a similar vein, item 25 (childhood traumas), loaded negatively on factor 5 ("diagnosis"), for the providers but positively on factor 3 ("pathology"), for the consumers. The reason for this may lie in the acceptance the general public has of the view taken since Freud's writings on the influence of childrearing practices on the development of personality, that traumatic experiences during childhood cause mental illness. Furthermore, "hysteria" of women was supposed to be the consequence of unresolved conflicts during childhood. Providers seem to reject this view with the knowledge that in reality women may be <u>diagnosed</u> as developing mental health problems due to traumatic childhood experiences rather than actually suffering from them.

On the other hand, the item stating that women suffer from <u>different</u> <u>types</u> of mental health problems than men, fell under the "Medical Model" factor for the providers. Thus, the interpretation is that because of the biological differences between men and women, women develop different mental health problems. This item (different types), was under one of the uninterpreted factors for the consumers.

Surprisingly, item 3 (psychiatrists), formed a factor on it's own for the providers whereas for the consumers it loaded on factor 4 ("Medical Model"), which would be the expected finding.

The factors of "diagnosis" and "treatment" were the other factors to emerge from the providers data which were not apparent for the consumers. Both factors could be interpeted as issues in which providers are more knowledgable. However, in the factor analysis forcing three factors neither of these factors emerged, and all but one of the items appeared under another factor.

In comparing the providers and consumers on the three forced factors we find some interesting differences. As mentioned earlier, factor 1 ("external causes"), for the consumers combined factor 1 and factor 2 from the original factor analysis suggesting that the distinction between women's mental illness and mental illness generally is not so clear to the consumers. The factor of "external causes" for the providers on the other hand, combined "external causes" and "pathology" indicating belief about the interaction between them. This meant that although the "Medical Model" was represented by the combination of "pathology" and "Medical Model" for the consumers which was an expected result, it was represented just by the "Medical Model" for the providers. (Item 3 did load .36 on this factor for the providers).

An interesting finding was that the providers did not have a "diagnosis" factor when three factors were forced. Item 21 concerned with women's diagnosis loaded on factor 1 ("external causes of women's mental illness"), and likewise, item 25 (childhood traumas), loaded negatively on factor 1. When three factors were forced from the consumers data a factor labeled "diagnosis" did emerge which included items 16 (women suffering from different types of mental illness), 21 (diagnosis of women), 9 (diagnosis as a subjective process), and 13 (expectations of society).

In summarizing these findings, providers may be interpreted as making attributions at a more specific level than the consumers. For example, providers make the distinction between women's mental illness and mental illness in general, consumers do not. Providers are also aware of the interactive process occurring between external causes and the pathological conditions of mental illness, consumers make attributions on the basis of pathology and the "disease model". However, an unexpected finding was the factor of "diagnosis" for the consumers which emerged in the second factor analysis and not the first whereas it was vice versa for the providers.

Therefore, although when looking at Table 15 it appears that the providers and consumers are very similar to each other on the factors, when examined in detail some important differences do come to light. The main implication from these findings is that the two populations may be using different criteria for making their attributions even though the framework in which they are making them is similar. However, as discussed earlier, these results are by no means conclusive and really serve to point the direction in which further research should go with respect to understanding dimensionality underlying attributions towards mental illness.

DEMOGRAPHIC VARIABLES AND ATTRIBUTIONS

The third aim of the study was to examine demographic and social variables for their influence on the attributions of providers and consumers.

Before discussing the results from the analysis of variance a cautionary note should be made concerning the interpretation of these results. It was felt that in order to see exactly how much input each variable had on the scales, correlations should be done between all demographic variables. However, due to nature of the variables and the number of missing values, correlational analyses were inappropriate. Therefore, although some of the findings were significant and do offer some insight into the possible effects of demographic and social variables on attributions, we should be wary of taking them at face value.

Providers

The first finding from the analysis of variance suggested that providers differed in their responses on the "Medical Model" scale according to the specific position they held. The low mean rating of the "clinical/medical" occupational group suggests that these people were more likely to agree that women suffer from different types of mental health problems than men due to an imbalance of chemicals in the brain and not due to a subjective diagnosis process. Medication is thus considered to be the most beneficial way to treat mental illness. This finding is not a surprising one in so far as the Medical Model stems from the view of mental illness as a disease and thus people working in a more medically oriented field would be expected to, on the most part, adhere to this approach.

In support of the above interpretation was the finding that the qualifications of the providers also influenced the responses of the providers on this scale. The lowest

mean rating was for people that were "medically trained", again suggesting that they agree with the Medical Model interpretation of causes and treatment of mental illness.

Surprisingly, there were no significant differences between type of services and treatment offered or the agency the provider worked in for any of the scales. On the basis that treatment techniques and orientations are couched in different frameworks and approaches to mental health problems, as are the particular agency using these treatment methods it would be expected that these differences would be highlighted in terms of the scales.

Age and number of years employed in the individuals present position were also not significant influences on the attributions of the providers. It seems that the qualifications and training of the person effect attributions rather than age.

Consumers

Contrary to the providers, the age of the consumers affected the attributions on both the "external causes" and "Medical Model" scales. Specifically, people between the ages 46 and 55 were more likely to agree that external situations cause mental illness than people between the ages 56 and 70. This finding would be in accordance with the assumption that older people tend to believe mental illness is a disease caused by physiological conditions rather than the pressures from society. No other age groups differed significantly in terms of this scale which does lead to questioning of this assumption. However, although no two groups differed significantly on scale 2 ("Medical Model"), the 56-70 year age group had the second lowest mean rating indicating their agreement with the Medical Model orientation. The 18-30 year age group had the lowest mean rating though. A tentative explanation for this could be that the younger age group are more aware of the advancement and increase in

knowledge concerning the activity of the brain in some mental health conditions and thus are attributing mental illness to physiological and chemical causes.

Whether the consumer had sought treatment before or not also had an effect on the responses on scales 1 and 3 ("external causes" and "diagnosis"). The mean was higher for those that had sought treatment before in both scales suggesting that these people are more likely to agree with the notion of external conditions leading to mental illness and that mental illness can be a diagnostic label assigned by a subjective process based on expectations of the diagnostician. The factor of "diagnosis" was interpreted earlier as a sub-group of causes (specifically, external causes), and the finding above lends support to this notion. This particular result is opposite to what we might expect though, that is, people seeking treatment by definition may be more inclined to have a Medical Model orientation. However, the majority of the people sought help from a private agency and in actual fact tended to agree that mental illness is due to external causes. This has been explained below in terms of social class and would explain why, in my sample, the people going for help do not adhere to the Medical Model. One interpretation of the result could be that people experiencing a mental health problem and treatment are probably more familiar with the diagnostic process as well as the circumstances that may lead to mental illness and so do not see it in the same way as a physical disease.

The type of treatment sought (public or private), who they were treated by and the sort of treatment all influenced the attributions on scale 1 (external causes), and not scales 2 and 3. Those people that had sought treatment privately (78%) were more likely to agree that mental illness was due to external causes, than those that had gone for public help (22%). This may be explained with reference to the fact that private help is usually expensive and therefore those people who can afford this may be more

middle class. Horwitz (1982) reported that the recognition of mental illness varies directly with social class such that higher social classes are more likely to recognize and label mental illness (lower classes are more likely to be labeled). Related to this was the finding that the middle and upper classes view a greater range of behaviors as "mental illness" in comparison with the lower classes who view only the most bizarre behaviors as "mental illness" Thus, the middle and upper classes also seek help for a range of interpersonal and emotional problems whereas the lower classes tend to interpret problems as symptomatic of physical disorders. The assumption that would have to be made here is that the people in my sample who have sought help come from the middle class as I have no direct measure of social class in my data.

In a related manner, the mean rating for people seeing a social worker was lower than for those people who saw a psychologist or a psychiatrist. As psychologists and psychiatrists are more likely to be in private practice than a social worker, middle class people (as interpreted in my sample), are more likely to see them, and as has already been stated , it is these people that believe external conditions can lead to mental illness. However, we could argue that people seeking treatment may "learn" certain values from the providers and as psychologists and psychiatrists had the second lowest mean rating on the "Medical Model" scales the values they would be presenting would be medically oriented ones and not those that the consumers in this instance are holding. Hence, there is a marked difference between providers' orientation and the consumers' who receive help from these providers.

The sort of treatment received was also shown to influence the responses on scale 1 and although no two groups were significantly different "group therapy" had the lowest mean score which suggests that people in this sort of treatment plan did not tend to adhere to the view that external situations cause mental illness. A possible

explanation for this would be that the treatment itself is based on the premise that individuals have some control over their lives and thus over their particular circumstances. Therefore, to believe that external factors can cause mental health problems would not be in accordance with the treatment regime and thus not conducive to alleviating the problem.

The final significant result for the consumers was that if they knew anybody that suffers or had suffered from a mental illness they were less likely to agree that mental illness is due to a chemical imbalance etc, that is, the "Medical Model". Scales 1 and 3 ("external cause" and "diagnosis"), however were not influenced by this variable.

Marital status, occupation, rating of treatment, and where they would go if they were suffering from a mental health problem all had no significant effect on the attributions on each scale.

In summary, the only significant findings for the providers were on the "Medical Model" scale, and indicated that the more medically oriented occupations and qualifications were more adherent to the Medical Model philosophy. For the consumers, the general picture that emerged was that if people knew someone who had suffered from a mental health problem or if they themselves had ever had to seek treatment for a problem, they tended to attribute mental illness to external causes. When we examined the people who had sought treatment it appeared as if the sub-group seeking private treatment, probably from psychologists or psychiatrists were the people that held these external causal attributions towards mental illness, although these providers had the second lowest mean rating on the "Medical Model" scale indicating adherence to the Medical Model view in oppositon to the consumers external orientation. The implication is that the more involved and familiar individuals are with the mental health domain the more likely they are to agree with the notion of mental illness being caused by external

factors. In addition, we see that different sub-populations in society may indeed hold different attributions towards mental illness precisely because they <u>are</u> different people with varying values, beliefs and views of the world.

A final point to make is once again the caution that must be taken when interpreting the results in this study. The above analysis of variance was computed using the loadings on the factors that emerged from a factor analysis that we have already said should not be taken at face value. The results and findings reported here are most beneficial and meaningful if they are interpreted and utilized to point the way for further research in the very complex domain of dimensionality underlying attributions towards mental illness.

Chapter 6

Concluding Comments

Dimensionality underlying attributions towards mental illness, on the basis of the findings in the present study, is a complex domain that cannot be explained with reference to just two dimensions. With regard to the previous literature, I have proposed that in my sample etiology and treatment do not appear as two separate dimensions as Hill and Bales and Brickman et al assumed, although this does not automatically dismiss these researchers' assumptions as completely false. In actual fact, precisely because etiology and treatment tended to load together under one factor we can interpret them as being related so that if a person has a certain belief concerning etiology then they are likely to hold a belief concerning treatment that "matches" or corresponds to it. Hill and Bales' correlational findings also support this idea.

Brickman et al's framework was harder to recognize in the present study especially due to the lack of "responsibility" questions. A stronger data set with appropriate questions may illustrate some interesting findings and possibly suggest that the models and assumptions of Brickman et al are also relevent in a framework of dimensionality underlying attributions towards mental illness.

The conclusions to be drawn from the dimensionality issue are that a more complex framework is more appropriate in explaining dimensionality and attributions although the ideas implicit in the assumption of two dimensions (the relationship between treatment and etiology), are probably part of that framework.

The main point that arose from the comparison of the providers and consumers is that there are differences between these populations with regard to the factors that

emerged even though they appeared very similar on the surface. The providers and consumers may be using different criteria for making attributional judgements on these factors even though the factors themselves are the same. This would indicate that there is something implicit to the interpretation of the factors by providers and consumers that makes them differ in the way that attributions are made under these factors.

To reinforce this notion some social and demographic variables were shown to influence the factors and again the implication is that sub-populations in society should not be assumed to make attributions using exactly the same criteria even if a similar framework is being used.

An important point I would like to bring up here is that mental illness means different things to people from different cultures. I mentioned earlier that the Western culture presents a particular orientation or world view towards the body and mind which is very different from the orientation presented in the Eastern cultures. Frankel (1980) was also concerned with these two points and brought them together to propose that attitudes and attributions towards mental illness may vary according to the political stance that pervades a particular culture at a particular time.

We can conclude from this that we should not assume that dimensionality underlying attributions is necessarily a stable construct that is not affected by social/demographic, cultural, political, geographical factors as well as the passage of time. Longitudinal research would be beneficial in this regard.

Future researchers may learn from the findings presented here not so much what the framework for understanding dimensionality looks like but rather that the approach to dimensionality should be broad enough to allow for the possibility of different criteria being used even if there is only one basic framework for understanding dimensionality underlying attributions towards mental illness.

The long-term implications of this understanding for people suffering from a mental health problem obviously lie in being aware that there may be a conflict of values within the therapeutic relationship due to the participants using different criteria in their attributions towards mental illness.

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Appendix 1 AGENCIES PARTICIPATING IN THE SURVEY

Mental Health / Mental Retardation
Drug and Alcohol
Department of Public Welfare
Board of Assistance
Rehabilitation Facility
Counseling Center for Eating Disorders
Private Mental Health Practice
Psychiatric Inpatient
Advocacy Mental Health Agency
YWCA
Nurses Registry
College Counseling Service
Marriage and Family Therapy
Mentally Retarded Adult Center
Psychological Services
Nursing Home
Domestic Violence Project
Lutheran Inner Mission Society
Community College
Children and Youth
Aging Services
Cooperative Extension Service
Prison
Private Psychiatric Outpatient Clinic
Hospital
Daycare Center
Home Health Agency
Mental Health Hospital
Private College
Treatment Center for Children and Family
Private Counseling
School Counseling
Department of Human Services
Child Welfare
Outreach Aftercare with Adolescents
Planned Parenthood
Family Guidance Clinic
Catholic Society Agency
American Cancer Society

Appendix 2

PROVIDERS SURVEY

WOMEN'S MENTAL HEALTH

REGIONAL TASK FORCE ON WOMEN'S MENTAL HEALTH

PLEASE CHECK OR FILL IN APPROPRIATE ANSWER

AGENCY: ____ MH/MR ____ DRUG & ALCOHOL ____ OTHER (Specify)

_____

____ PUBLIC ____ PRIVATE

ADDRESS: _____ _____ MALE

_____ _____ FEMALE

_____ _____ AGE

TELEPHONE: _____

OCCUPATION: _____

QUALIFICATIONS YOU HAVE FOR YOUR POSITION: _____

_____

_____

NUMBER OF YEARS EMPLOYED IN THIS FIELD: _____

USING THE FOLLOWING RESPONSE SCALE, PLEASE INDICATE YOUR ANSWER BY CHECKING THE APPROPRIATE LETTER FOR EACH OF THE FOLLOWING:

A - Agree strongly
a - Agree somewhat
? - Undecided
d - Disagree somewhat
D - Disagree strongly

A a ? d D 1. Too little attention and concern is directed towards mental health issues.

A a ? d D 2. "Mental Illness" refers to extreme states whereby a person cannot function properly in society.

A a ? d D 3. Psychiatrists are the only people who can successfully treat a mental illness.

A a ? d D 4. Less than 10% of the population will suffer from any mental health problems during their life time.

A a ? d D 5. Many mental health problems arise out of an inability to cope with life and its stressful problems. e.g. - unemployment.

A a ? d D 6. Medication is usually the most beneficial way to treat mental illness.

A a ? d D 7. Most mental illnesses are passed down from generation to generation.

A a ? d D 8. A person with a mental illness cannot successfully interact with other people.

A a ? d D 9. A diagnosis of mental illness is a subjective process based on expectations and preconceived ideas of the diagnostician.

A a ? d D 10. Serious mental illnesses like schizophrenia usually last a life time.

A a ? d D 11. Counseling or support groups are the most appropriate way of helping people with mental health problems.

A a ? d D 12. Most serious mental illnesses are due to an imbalance of chemicals in the brain.

A a ? d D 13. Some mental health conditions are the product of a society with unreasonable expectations.

A a ? d D 14. There are not enough services available for people suffering from mental health problems.

A a ? d D 15. Women suffer from more mental health problems than men.

A a ? d D 16. Women suffer from different types of mental health problems than men.

IF YOU RESPONDED A OR a TO STATEMENT 15 AND / OR 16 PLEASE ANSWER THE FOLLOWING:

A a ? d D 17. Women suffer more mental health problems than men due to differences in the expected role behaviors of men and women.

A a ? d D 18. Women suffer different types of mental health problems than men due to differences in the expected role behaviors of men and women.

A a ? d D 19. Women suffer more mental health problems than men because of the difference in "personalities" of men and women.

A a ? d D 20. Women suffer different types of mental health problems than men because of the difference in "personalities" of men and women.

A a ? d D 21. Women suffer more mental health problems than men because of a reflection of diagnostic procedures among mental health professionals.

A a ? d D 22. Women suffer different types of mental health problems than men because of a reflection of diagnostic procedures among mental health professionals.

A a ? d D 23. Women suffer more mental health problems than men because of society and its pressures on women leading to such problems.

A a ? d D 24. Women suffer different types of mental health problems than men because of society and its pressures on women leading to such problems.

A a ? d D 25. Women suffer more mental health problems than men due to traumatic experiences during childhood.

A a ? d D 26. Women suffer different types of mental health problems than men due to traumatic experiences during childhood.

USING THE FOLLOWING RESPONSE SCALE, KEEPING IN MIND YOUR OWN AREA, PLEASE RATE THE FOLLOWING:

VERY MUCH A PROBLEM	A PROBLEM	A SLIGHT PROBLEM	NOT A PROBLEM
1	2	3	4

UNLESS YOUR RESPONSE IS 4 - PLEASE STATE WHAT YOU FEEL THE BARRIERS ARE AND WHAT THEIR POSSIBLE CAUSES MIGHT BE FOR QUESTIONS 27 THROUGH 30.

27. _____ The accessibility of mental health services for women.

EXPLAIN:

28. _____ The affordability of mental health services for women.

EXPLAIN:

29. _____ The appropriateness of mental health services for women.

EXPLAIN:

30. What services do you actually offer in your agency.

EXPLAIN:

31. What type of treatment is being offered in your agency?

PLEASE CHECK: _____ PSYCHOTHERAPY

_____ GROUP THERAPY

_____ INDIVIDUAL THERAPY

_____ PEER COUNSELING

_____ PSYCHOTROPIC DRUGS

_____ SUPPORT GROUPS

_____ OTHER (please specify) _____

_____

_____

32. What treatments, if any, are used more by women than men.

33. Do more women than men come to your agency.

PLEASE CHECK: _____ YES _____ NO _____ UNKNOWN

34. Are there any specific circumstances which you think could be directly related to the development of women's mental health problems. e.g. - unemployment, poverty, single parenting, etc.

EXPLAIN:

35. If so, what preventative measures should be adopted in order to reduce this development.

EXPLAIN:

36. a. Do you think that <u>Black</u> <u>Women</u> have special needs concerning mental health.

Please check: _____ YES _____ NO _____ UNKNOWN

EXPLAIN:

b. Does your agency have a specific policy and services to address these mental health needs.

Please check: _____ YES _____ NO _____ UNKNOWN

EXPLAIN:

c. To what extent is the service being provided to meet these needs.

Please check:

_____ DON'T KNOW _____ NOT AT ALL _____ A LITTLE BIT

_____ SOMEWHAT _____ A GREAT DEAL

EXPLAIN:

d. If the services are being provided to what extent do you feel they are successful in meeting these needs.

Please check:

_____ DON'T KNOW _____ NOT AT ALL _____ A LITTLE BIT

_____ SOMEWHAT _____ A GREAT DEAL

EXPLAIN:

37. a. Do you think that <u>Hispanic</u> <u>Women</u> have special needs concerning mental health.

Please check: _____ YES _____ NO _____ UNKNOWN

EXPLAIN:

b. Does your agency have a specific policy and services to address these mental health needs.

Please check: _____ YES _____ NO _____ UNKNOWN

EXPLAIN:

c. To what extent is the service being provided to meet these needs.

Please check:

_____ DON'T KNOW _____ NOT AT ALL _____ A LITTLE BIT

_____ SOMEWHAT _____ A GREAT DEAL

EXPLAIN:

d. If the services are being provided to what extent do you feel they are successful in meeting these needs.

Please check:

_____ DON'T KNOW _____ NOT AT ALL _____ A LITTLE BIT

_____ SOMEWHAT _____ A GREAT DEAL

EXPLAIN:

38. a. Do you think that <u>Caucasian</u> <u>Women</u> have special needs concerning mental health.

Please check: _____ YES _____ NO _____ UNKNOWN

EXPLAIN:

b. Does your agency have a specific policy and services to address these mental health needs.

Please check: _____ YES _____ NO _____ UNKNOWN

EXPLAIN:

c. To what extent is the service being provided to meet these needs.

Please check:

_____ DON'T KNOW _____ NOT AT ALL _____ A LITTLE BIT

_____ SOMEWHAT _____ A GREAT DEAL

EXPLAIN:

d. If the services are being provided to what extent do you feel they are successful in meeting these needs.

Please check:

_____ DON'T KNOW _____ NOT AT ALL _____ A LITTLE BIT

_____ SOMEWHAT _____ A GREAT DEAL

EXPLAIN:

39. a. Do you think that <u>Other</u> <u>Ethnic/Racial</u> <u>Minorities</u> have special needs concerning mental health.

Please check: _____ YES _____ NO _____ UNKNOWN

EXPLAIN:

b. Does your agency have a specific policy and services to address these mental health needs.

Please check: _____ YES _____ NO _____ UNKNOWN

EXPLAIN:

c. To what extent is the service being provided to meet these needs.

Please check:

_____ DON'T KNOW _____ NOT AT ALL _____ A LITTLE BIT

_____ SOMEWHAT _____ A GREAT DEAL

EXPLAIN:

d. If the services are being provided to what extent do you feel they are successful in meeting these needs.

Please check:

_____ DON'T KNOW _____ NOT AT ALL _____ A LITTLE BIT

_____ SOMEWHAT _____ A GREAT DEAL

EXPLAIN:

40. a. Do you think that <u>Lesbian</u> <u>Women</u> have special needs concerning mental health.

Please check: _____ YES _____ NO _____ UNKNOWN

EXPLAIN:

b. Does your agency have a specific policy and services to address these mental health needs.

Please check: _____ YES _____ NO _____ UNKNOWN

EXPLAIN:

c. To what extent is the service being provided to meet these needs.

Please check:

_____ DON'T KNOW _____ NOT AT ALL _____ A LITTLE BIT

_____ SOMEWHAT _____ A GREAT DEAL

EXPLAIN:

d. If the services are being provided to what extent do you feel they are successful in meeting these needs.

Please check:

_____ DON'T KNOW _____ NOT AT ALL _____ A LITTLE BIT

_____ SOMEWHAT _____ A GREAT DEAL

EXPLAIN:

41. a. Do you think that Older Women have special needs concerning mental health.

Please check: _____ YES _____ NO _____ UNKNOWN

EXPLAIN:

b. Does your agency have a specific policy and services to address these mental health needs.

Please check: _____ YES _____ NO _____ UNKNOWN

EXPLAIN:

c. To what extent is the service being provided to meet these needs.

Please check:

_____ DON'T KNOW _____ NOT AT ALL _____ A LITTLE BIT

_____ SOMEWHAT _____ A GREAT DEAL

EXPLAIN:

d. If the services are being provided to what extent do you feel they are successful in meeting these needs.

Please check:

_____ DON'T KNOW _____ NOT AT ALL _____ A LITTLE BIT

_____ SOMEWHAT _____ A GREAT DEAL

EXPLAIN:

42. a. Do you think that <u>Rural</u> <u>Women</u> have special needs concerning mental health.

Please check: _____ YES _____ NO _____ UNKNOWN

EXPLAIN:

b. Does your agency have a specific policy and services to address these mental health needs.

Please check: _____ YES _____ NO _____ UNKNOWN

EXPLAIN:

c. To what extent is the service being provided to meet these needs.

Please check:

_____ DON'T KNOW _____ NOT AT ALL _____ A LITTLE BIT

_____ SOMEWHAT _____ A GREAT DEAL

EXPLAIN:

d. If the services are being provided to what extent do you feel they are successful in meeting these needs.

Please check:

_____ DON'T KNOW _____ NOT AT ALL _____ A LITTLE BIT

_____ SOMEWHAT _____ A GREAT DEAL

EXPLAIN:

43. a. Do you think that <u>Poor</u> <u>Women</u> have special needs concerning mental health.

Please check: _____ YES _____ NO _____ UNKNOWN

EXPLAIN:

b. Does your agency have a specific policy and services to address these mental health needs.

Please check: _____ YES _____ NO _____ UNKNOWN

EXPLAIN:

c. To what extent is the service being provided to meet these needs.

Please check:

_____ DON'T KNOW _____ NOT AT ALL _____ A LITTLE BIT

_____ SOMEWHAT _____ A GREAT DEAL

EXPLAIN:

d. If the services are being provided to what extent do you feel they are successful in meeting these needs.

Please check:

_____ DON'T KNOW _____ NOT AT ALL _____ A LITTLE BIT

_____ SOMEWHAT _____ A GREAT DEAL

EXPLAIN:

44. a. Do you think that Victims of Violence have special needs concerning mental health.

Please check: _____ YES _____ NO _____ UNKNOWN

EXPLAIN:

b. Does your agency have a specific policy and services to address these mental health needs.

Please check: _____ YES _____ NO _____ UNKNOWN

EXPLAIN:

c. To what extent is the service being provided to meet these needs.

Please check:

_____ DON'T KNOW _____ NOT AT ALL _____ A LITTLE BIT

_____ SOMEWHAT _____ A GREAT DEAL

EXPLAIN:

d. If the services are being provided to what extent do you feel they are successful in meeting these needs.

Please check:

_____ DON'T KNOW _____ NOT AT ALL _____ A LITTLE BIT

_____ SOMEWHAT _____ A GREAT DEAL

EXPLAIN:

45. a. Do you think that Women with Interpersonal Problems (divorce, empty nest, isolation, marriage, motherhood, singlehood, single parenting, widowhood) have special needs concerning mental health.

Please check: _____ YES _____ NO _____ UNKNOWN

EXPLAIN:

b. Does your agency have a specific policy and services to address these mental health needs.

Please check: _____ YES _____ NO _____ UNKNOWN

EXPLAIN:

c. To what extent is the service being provided to meet these needs.

Please check:

_____ DON'T KNOW _____ NOT AT ALL _____ A LITTLE BIT

_____ SOMEWHAT _____ A GREAT DEAL

EXPLAIN:

d. If the services are being provided to what extent do you feel they are successful in meeting these needs.

Please check:

_____ DON'T KNOW _____ NOT AT ALL _____ A LITTLE BIT

_____ SOMEWHAT _____ A GREAT DEAL

EXPLAIN:

46. a. Do you think that Women with Physical and Reproductive Problems (arthritis, cancer, heart disease, hypoglycemia, osteoporosis, abortion, infertility, menopause, PMS, pregnancy) have special needs concerning mental health.

Please check: _____ YES _____ NO _____ UNKNOWN

EXPLAIN:

b. Does your agency have a specific policy and services to address these mental health needs.

Please check: _____ YES _____ NO _____ UNKNOWN

EXPLAIN:

c. To what extent is the service being provided to meet these needs.

Please check:

_____ DON'T KNOW _____ NOT AT ALL _____ A LITTLE BIT

_____ SOMEWHAT _____ A GREAT DEAL

EXPLAIN:

d. If the services are being provided to what extent do you feel they are successful in meeting these needs.

Please check:

_____ DON'T KNOW _____ NOT AT ALL _____ A LITTLE BIT

_____ SOMEWHAT _____ A GREAT DEAL

EXPLAIN:

47. a. Do you think that <u>Physically</u> <u>Disabled</u> <u>Women</u> have special needs concerning mental health.

Please check: _____ YES _____ NO _____ UNKNOWN

EXPLAIN:

b. Does your agency have a specific policy and services to address these mental health needs.

Please check: _____ YES _____ NO _____ UNKNOWN

EXPLAIN:

c. To what extent is the service being provided to meet these needs.

Please check:

_____ DON'T KNOW _____ NOT AT ALL _____ A LITTLE BIT

_____ SOMEWHAT _____ A GREAT DEAL

EXPLAIN:

d. If the services are being provided to what extent do you feel they are successful in meeting these needs.

Please check:

_____ DON'T KNOW _____ NOT AT ALL _____ A LITTLE BIT

_____ SOMEWHAT _____ A GREAT DEAL

EXPLAIN:

48. Please list any needs that you feel may be unique in your area.

49. Are there any services available in your area which you feel may be unique for women.

50. What do you consider the priority issues involving women and mental health in your area.

51. Are there any other issues concerning women's mental health which you would like to raise or any further input that you would like to share.

Appendix 3

CONSUMERS SURVEY

WOMEN'S MENTAL HEALTH

REGIONAL TASK FORCE ON WOMEN'S MENTAL HEALTH

PLEASE CHECK OR FILL IN APPROPRIATE ANSWER

NAME OF COUNTY:

_____

AGE: _____ 18–30

_____ 31–45

_____ 46–55

_____ 56 AND OVER

_____ MALE

_____ FEMALE

OCCUPATION:

_____

MARITAL STATUS: _____ SINGLE

_____ MARRIED

_____ DIVORCED

_____ SEPARATED

_____ WIDOWED

USING THE FOLLOWING RESPONSE SCALE, PLEASE INDICATE YOUR ANSWER BY CHECKING THE APPROPRIATE LETTER FOR EACH OF THE FOLLOWING:

A - Agree strongly
a - Agree somewhat
? - Undecided
d - Disagree somewhat
D - Disagree strongly

A a ? d D	1.	Too little attention and concern is directed towards mental health issues.
A a ? d D	2.	"Mental Illness" refers to extreme states whereby a person cannot function properly in society.
A a ? d D	3.	Psychiatrists are the only people who can successfully treat a mental illness.
A a ? d D	4.	Less than 10% of the population will suffer from any mental health problems during their life time.
A a ? d D	5.	Many mental health problems arise out of an inability to cope with life and its stressful problems. e.g. - unemployment.
A a ? d D	6.	Medication is usually the most beneficial way to treat mental illness.
A a ? d D	7.	Most mental illnesses are passed down from generation to generation.
A a ? d D	8.	A person with a mental illness cannot successfully interact with other people.
A a ? d D	9.	A diagnosis of mental illness is a subjective process based on expectations and preconceived ideas of the diagnostician.
A a ? d D	10.	Serious mental illnesses like schizophrenia usually last a life time.
A a ? d D	11.	Counseling or support groups are the most appropriate way of helping people with mental health problems.
A a ? d D	12.	Most serious mental illnesses are due to an imbalance of chemicals in the brain.
A a ? d D	13.	Some mental health conditions are the product of a society with unreasonable expectations.

A a ? d D 14. There are not enough services available for people suffering from mental health problems.

A a ? d D 15. Women suffer from more mental health problems than men.

A a ? d D 16. Women suffer from different types of mental health problems than men.

IF YOU RESPONDED A OR a TO STATEMENT 15 AND / OR 16 PLEASE ANSWER THE FOLLOWING:

A a ? d D 17. Women suffer more mental health problems than men due to differences in the expected role behaviors of men and women.

A a ? d D 18. Women suffer different types of mental health problems than men due to differences in the expected role behaviors of men and women.

A a ? d D 19. Women suffer more mental health problems than men because of the difference in "personalities" of men and women.

A a ? d D 20. Women suffer different types of mental health problems than men because of the difference in "personalities" of men and women.

A a ? d D 21. Women suffer more mental health problems than men because of a reflection of diagnostic procedures among mental health professionals.

A a ? d D 22. Women suffer different types of mental health problems than men because of a reflection of diagnostic procedures among mental health professionals.

A a ? d D 23. Women suffer more mental health problems than men because of society and its pressures on women leading to such problems.

A a ? d D 24. Women suffer different types of mental health problems than men because of society and its pressures on women leading to such problems.

A a ? d D 25. Women suffer more mental health problems than men due to traumatic experiences during childhood.

A a ? d D 26. Women suffer different types of mental health problems than men due to traumatic experiences during childhood.

27. Have you ever had to seek treatment for any mental illness?

PLEASE CHECK: _____ YES _____ NO

IF YES, PLEASE ANSWER THE FOLLOWING:

A. Type of service: _____ PRIVATE
_____ PUBLIC

B. Treated by: _____ PSYCHOLOGIST
_____ PSYCHIATRIST
_____ SOCIAL WORKER
_____ OTHER (please specify) _____

C. What sort of treatment received:

_____ PSYCHOTHERAPY
_____ GROUP THERAPY
_____ INDIVIDUAL THERAPY
_____ PEER COUNSELING
_____ DRUGS
_____ SUPPORT GROUPS
_____ OTHER (please specify) _____

D. How would you rate the treatment you received:

_____ EXCELLENT
_____ GOOD
_____ FAIR
_____ NOT VERY GOOD
_____ USELESS

28. If you thought you needed to see someone about a mental health problem, where would you go: _____

29. Do you know anyone (friends or family) who has suffered/suffers from a mental health problem.

_____ YES _____ NO

30. Which conditions below do you consider to be mental disorders.

_____ SCHIZOPHRENIA
_____ DEPRESSION
_____ ALCOHOLISM
_____ HYSTERIA
_____ PRE-MENSTRUAL SYNDROME
_____ EATING DISORDERS
_____ DRUG ADDICTION

31. Which conditions below do you think women suffer from more than men.

_____ SCHIZOPHRENIA
_____ DEPRESSION
_____ ALCOHOLISM
_____ HYSTERIA
_____ PRE-MENSTRUAL SYNDROME
_____ EATING DISORDERS
_____ DRUG ADDICTION

32. Please check any of the following that you think could be directly related to the development of women's mental health problems.

_____ UNEMPLOYMENT
_____ POVERTY
_____ FAMILY RESPONSIBILITIES
_____ ISOLATION

33. Please check any of the following specific populations that you think have special needs concerning mental health.

_____ CAUCASIAN WOMEN
_____ ETHNIC/RACIAL MINORITIES
_____ POOR WOMEN
_____ OLDER WOMEN
_____ VICTIMS OF VIOLENCE
_____ WOMEN WITH PHYSICAL AND REPRODUCTIVE PROBLEMS (arthritis, cancer, heart disease, hypoglycemia, osteoporosis, abortion, infertility, menopause, PMS, pregnancy)
_____ WOMEN WITH INTERPERSONAL PROBLEMS (divorce, etc.)
_____ PHYSICALLY DISABLED WOMEN
_____ WORKING MOTHERS
_____ LESBIANS

34. Do you have insurance to cover treatment for mental illness.

_____ YES _____ NO

35. Do you believe that there should be mandatory insurance to cover mental illness.

_____ YES _____ NO _____ UNDECIDED

36. Are there any other issues concerning women's mental health which you would like to raise or any further input that you would like to share?

Appendix 4 MEANS OBTAINED FROM ANALYSIS OF VARIANCE

Providers

Variable		Scale 1		Scale 2		Scale 3	
		Mean	SD	Mean	SD	Mean	SD
Age	18–30 years	15.5564	3.0262	7.7573	1.0292	8.1009	1.6993
	31–45	14.7551	1.8787	7.7173	1.5107	8.4561	1.9402
	46–55	15.3492	1.8504	8.3142	1.2088	8.2950	1.5666
	56–70	14.000	—	9.2400	—	9.0700	—
Agency	Welfare	15.0872	2.3155	8.1011	1.4771	8.4211	2.1827
	Counseling/Rehabilitation	14.2814	1.8331	7.9609	1.3223	8.7523	1.5354
	Psychiatric/Medical	14.5957	2.3608	7.4757	1.8231	8.4714	1.4762
	Church/Religious	15.5475	2.3729	8.7725	0.6667	7.5150	1.7760
	Mental Health Agencies	13.9669	2.5443	7.9846	1.8202	7.6062	1.4826
	Crime Related	15.5083	1.6822	7.5433	0.7057	9.0233	0.8925
Agency Type	Public	14.8161	2.067	8.0111	1.4776	8.2843	1.7322
	Private	14.5303	2.0025	8.1185	1.0783	8.5053	1.8470
Occupation	Supervisory	14.6811	2.1285	8.2705	1.3282	8.8816	1.4242
	Clinical/Medical	14.8275	2.6124	7.9292	1.2775	7.4842	2.2557
	Counselor/Therapist	14.5611	1.8644	7.7337	1.3617	8.1329	1.8190
	Educator/Administrator	14.6471	2.2806	7.4371	1.7338	8.9700	1.0341
Qualifs.	Degree	15.4290	2.4490	8.2453	1.1406	8.8053	1.3877
	Masters	14.4910	1.5518	7.9515	1.2794	8.6000	1.7415
	PhD.	14.0733	3.2635	7.1033	2.2857	10.1900	0.9035
	Medical Training	14.1275	1.6178	7.8188	1.3311	7.1450	2.2552
	Specific Occ. Training	14.1176	2.0063	7.6824	1.4080	9.7959	1.7174
	Experience in Field	15.5350	1.9674	8.7550	0.7100	9.1050	1.4816
	Administration/Education	12.4150	0.4172	8.6650	0.7707	7.6300	0.3394
	Victim	12.0400	—	4.9200	—	4.8200	—

Variable		Scale 1		Scale 2		Scale 3	
		Mean	SD	Mean	SD	Mean	SD
Years Employed	1–5	14.6578	2.5479	7.6913	1.4495	8.4196	1.6820
	6–15	14.8327	1.9822	8.1157	1.1488	8.4578	1.7162
	16–30	14.4809	1.8763	7.9605	1.7018	8.4514	1.7626
Services/ Treatment Offered	Support	15.1064	1.6289	8.0382	1.4572	8.0491	1.6015
	Therapy/Counseling	14.7118	2.1301	8.1465	1.1929	8.5704	1.6723
	Non-Medical Assistance	15.0518	2.3909	7.8918	1.7039	8.6345	1.8551
	Education	14.3300	1.5342	6.9775	0.8320	8.4750	1.1766
	Medical	16.0075	1.8272	6.9725	1.0718	9.4725	1.3614

Consumers

Variable		Scale 1		Scale 2		Scale 3	
		Mean	SD	Mean	SD	Mean	SD
Age	18–30 years	11.4767	2.1194	10.0340	2.0942	6.5527	1.1071
	31–45	11.1690	2.2827	11.4329	1.9853	7.0081	1.2598
	46–55	12.4095	1.7990	11.6681	2.4299	7.1624	1.3262
	56–70	10.5665	1.8839	10.5220	1.7237	6.5890	1.2520
Marital Status	Single	10.3544	1.5914	11.4489	1.5427	6.0811	1.1160
	Married	11.4198	2.1649	11.2767	2.1531	7.0446	1.2248
	Divorced	11.9311	2.4930	9.5300	2.2977	6.7411	1.2723
	Separated	11.5800	2.5319	11.3917	2.0318	6.9800	1.3238
	Widowed	10.6478	2.1847	11.0156	1.4107	6.5456	1.4984
Occupation	Professional/Technical	11.4228	2.2106	11.2619	2.0101	6.9578	1.2087
	Clerical/Sales	10.8337	2.2322	11.3816	1.8704	6.7658	0.9397
	Factory/Service	11.8050	2.3068	9.3300	1.4779	7.1625	1.4472
	Student	11.2100	1.0124	10.9500	1.7542	6.1100	0.6802
	Housewife	11.3881	2.0951	11.0988	2.8781	7.1413	1.6174
	Retired	10.4014	2.5052	10.0471	2.0335	6.4300	1.0814
Sought Treatment	Yes	12.4556	1.9765	11.7660	1.6583	7.3340	1.2080
	No	11.0137	2.1735	10.9652	2.0848	6.8164	1.1993
Type of Agency	Private	12.7928	1.6291	11.6883	1.7718	7.0700	1.1244
	Public	10.4520	2.0272	11.6720	1.6381	7.5340	1.0581

Variable		Scale 1		Scale 2		Scale 3	
		Mean	SD	Mean	SD	Mean	SD
Treated by	Psychologist	12.5455	1.6265	12.3136	1.1341	7.1782	1.1440
	Psychiatrist	12.3375	1.5422	10.7813	1.9653	7.2400	1.3179
	Social Worker	8.6500	1.5132	11.5050	1.6900	7.1800	0.9192
	Medical Nurse	15.0800	—	9.6200	—	8.6800	—
	Mental Health Nurse	12.6300	—	13.8600	—	7.3300	—
	Support Groups	14.1800	—	13.2200	—	6.3600	—
	Counselor/Therapist	15.5000	—	12.7400	—	9.7400	—
Sort of Treatment	Psychotherapy	12.1167	0.6396	12.6300	1.0050	8.1433	0.9744
	Group Therapy	9.0800	2.1213	11.8200	1.2445	7.3850	0.6293
	Individual Therapy	12.7744	1.8484	11.6431	1.7889	6.9713	1.1125
	Drugs	12.3300	1.2493	11.1967	2.3850	7.6233	1.4228
	Understanding	15.5000	—	12.7400	—	9.7400	—
Treatment Rating	Excellent	13.1463	1.8118	11.4413	2.2490	7.2700	1.6071
	Good	11.9340	1.7110	12.1260	1.0945	7.1380	0.6448
	Fair	12.6620	3.0678	11.8200	1.1952	7.2400	1.4063
	Not Very Good	11.5625	1.7960	12.3250	1.4537	7.6075	0.9135
	Useless	12.3300	1.2493	11.1967	2.2385	7.6233	1.4228
Know Anyone	Yes	11.1477	2.1992	11.3726	1.7916	6.9095	1.1971
	No	11.4972	2.1956	10.6790	2.5046	6.9783	1.2525

Appendix 5

T - TEST CALCULATIONS

The formula for the t-test is shown here:

$$t = \frac{\overline{X_1} - \overline{X_2}}{S_p \sqrt{\frac{1}{n_1} - \frac{1}{n_2}}}$$

where

$$S_p = \sqrt{\frac{(n_1 - 1)\, s_1^2 + (n_2 - 1)\, s_2^2}{n_1 + n_2 - 2}}$$

The t-test was used to compare Providers and Consumers on Scale 2 ("external causes") and Scale 3 ("Medical Model"). The statistical values used in these calculations were obtained from SPSS(X) analysis and are listed in the table below.

	Scale 2		Scale 3	
	Providers	Consumers	Providers	Consumers
Number in Sample (n_i)	108	134	108	134
Mean ($\overline{X_i}$)	8.005	11.136	8.431	6.911
Variance (s_i^2)	1.717	4.059	2.814	1.447
Pooled Variance (S_p)	1.736		1.434	
t	42.55		25.01	
Degrees of Freedom	240		240	
Probability	< 0.001		< 0.001	

Upon substitution of these values into the equations above, one finds the values of the pooled variance (S_p) for Scales 2 and 3 to be 1.736 and 1.434 respectively. The corresponding t values were found to be 42.55 and 25.01 for Scales 2 and 3. With 240 degrees of freedom, these t values are significant at the 0.001 level.

Vita

Sarah Jane Clements was born in Hitchin, Hertfordshire England on January 22, 1961 to Douglas and Jean Clements. She received her Bachelor of Science (Honors) in Psychology at York University, York, England in June 1985. She came to the United States in September 1985 for graduate study. She completed a Master of Arts in Social Relations in 1988 at Lehigh University, Bethlehem, Pennsylvania.