Assessment of Psychiatric Attitudes

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Abstract

The assessment of psychiatric attitudes has been inconsistent over the years despite considerable evidence of the important role which they play in the efficacy of intervention with psychiatric illness. The development of an assessment tool which was both modern in theory and terminology was undertaken with the focus being on item construction and reliability. Three theoretical dimensions (Restrictive Control; Protective Benevolence; Humanistic) were consistently identified within the research literature, and items were written for these dimensions concerning five content areas (hospitals, treatment, professional staff, patients and illness). The final vetted battery was administered to 210 individuals, with factor analyses and reliability statistics calculated. After careful consideration of the limits of the present study, forty items were tentatively forwarded for further investigation in the development of a psychiatric attitudes assessment device.

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Over recent years there has been a shift in thinking about the optimal care and treatment of psychiatric patients (Appelbaum, 1986; Gorenstein, 1984; Kiesler et al., 1983; Toews et al.,1984; Turner, Madill and Solberg, 1984). This move has involved a concentrated effort away from the custodial orientation of the psychiatric hospital to a more 'humanitarian' community based perspective. The psychiatric hospital is therefore being seen increasingly as a treatment venue after community based resources have been exhausted, and for time limited intervention during acute phases of mental illness (Kiesler et al.,1983, Teplin, 1984). This movement towards deinstitutionalization, combined with decreases in governmental funding of alternative interventions, has served to make psychiatric patients an increasingly visible population within the community. Patients who cannot adapt frequently join the ranks of the destitute; others are filtered through the criminal justice system (Kiesler et al., 1983; Teplin, 1984). Thus while the professional psychiatric orientation is changing in a positive direction, public attitudes frequently remain negative (Neuhring, 1979; Teplin, 1984).

The potency of the mental illness label alone as a stigmatizing force can be seen when it is applied to behavioral categories. Sarbin and Mancuso (1970) found that behavior was viewed much more negatively when ascribed the mental illness label, than the same behavior without this label. This finding remained consistent regardless of the type of behavior described (ie. criminal vs. psychiatric). These negative attitudes do

seem to improve however, when individuals are provided information regarding the illness, or are provided interactive exposure to patients (Chinsky and Rappaport, 1970, Keith-Speigel and Speigel, 1970; Lieberman, 1970). Patients' attitudes are similarly modifed by the provision of brief orientation information provided in a positive and supportive format (Thompson and Mountain, 1986).

It is not solely the community which maintains negative psychiatric attitudes, but also the patients themselves. Swanson and Spitzer (1970) found that psychiatric inpatients maintained more negative attitudes towards other psychiatric patients and illness, than a comparison group of pre or post hospitalized patients, or their significant others. Similarly, the perceived prevalence of negative attitudes by psychiatric patients contributes to the level of stigma experienced by the patient. Farina et al.(1971) found that the belief that others knew of their status as psychiatric patients interfered with the patient's ability to problem solve. The patients perceived the problem solving task as more difficult, felt that their contributions were less appreciated by their partners and performed poorer than patients not functioning under such beliefs. Raters, blind of patient status, also rated the patients with negative attitudes as more anxious and tense and as being less well adjusted.

The maintenance of negative attitudes to psychiatric illness has serious implications. Patient attitudes, particularly those concerning institutionalization and

relationships with other people, are held to be differentially important in the prediction of therapeutic outcome. For example, Levine and Wittenborn (1971) found that psychotic patient's expressed attitudes toward other people, mental illness, and their own institutionalization, within 3 days of admission, were correlated with measures of improvement 4 years later. Thompson and Mountain (1986), found that after viewing an orientation videotape upon entering a psychiatric hospital, patients had more positive psychiatric attitudes and were generally perceived as adjusting better to their hospitalization (as suggested by a reduction in fear measures), than controls. In addition, Caine and Small (1968) found that patient attitudes toward psychiatric illness and treatment varied across institutions. These authors concluded that it was the orientation of the hospital in particular which influenced the patient attitudes. In a similar fashion, patients have been found to adopt attitudes toward psychiatric staff which seem to have clear implications for treatment. Kish, Solberg and Uecker (1971) found that staff were described by patients quite differently, depending on the staff's attitudes toward mental illness. Staff endorsing a restrictive control orientation towards psychiatric illness and patients were described as domineering, impatient and insensitive by patients. Staff endorsing protective-benevolence attitudes were held to be untrustworthy, aloof and distant. Finally, staff with humanistic attitudes were described as sensitive, understanding, open and honest. Thus a reciprocal interaction of attitudes exists between the staff and the

patients.

Attitude Theory

Thurstone (1931) defined attitude as a person's positive or negative evaluation of an object, implicit from his beliefs, actions and or intentions toward the object. This definition of attitude has largely held to the present, describing a general affect or orientation a person has toward an object. Ajzen and Fishbein(1980) stress however, that while an attitude may predispose an individual to certain actions towards an object, the specific behaviors which he/she exhibits will depend on the reinforcements which they receive for each. Modern attitude theory has changed it's orientation in an effort to explain the often inconsistent relationship between attitudes and behavior. In their 'Theory of Reasoned Action', Ajzen and Fishbein (1980) maintain that inconsistency arises from the use of global attitudes to predict specific behaviors. Attention must instead be directed to a given person's intention to perform a specific behavior, in a specific situation, at a specific time. Only when this paradigm is applied, as in the following example, does behavioral prediction reach a reasonable level of accuracy.

> "The behavioral criterion is thus not discrimination toward blacks but rather the performance of a single action (eg.administration of electric shock) with respect to a specific target (a particular black individual) in a given context (eg. a learning experiment), within a limited time period."
>
> (Ajzen and Fishbein, 1980;p.35)

A given person's intention to perform a specific behavior is determined by their evaluation of the outcome of the behavioral performance, and the social pressures which the individual believes are being applied by significant others for his/her performance of the behavior in question, within the defined situation.

> "Generally speaking, individuals will intend to perform a behavior when they evaluate it positively and when they believe that important others think they should perform it."
> (Ajzen and Fishbein, 1980;6)

While the prediction of specific behaviors from specific people in specific situations is arguably important, difficulties arise when a series or category of behaviors is of interest. The methodology of Ajzen and Fishbein (1980) requires the specification of multiple, discrete behavioral criteria on an a priori basis and always results in information which is restricted in it's generalizability, even to similar or related behaviors. Ajzen and Fishbein (1980) themselves recognize the limitations of this behavioral specificity in attitude research;

> "...while knowledge of a person's attitude can tell us little as to whether she will perform some particular behavior, it can tell us something about her overall pattern of behavior."
> (p.18)

If one wishes to predict specific behaviors, then the micro- behavioral approach of Ajzen and Fishbein (1980) is required. If one wishes to characterize an attitude pattern, then behavioral-contextual specificity is not as important. Following this line of reasoning, the present investigator felt it most appropriate to study the belief systems moderating

people's general attitudes towards psychiatric illness. General public attitudes might then be more amenable to attempts to change erroneous beliefs and improve negative attitudes. Changing these attitudes according to Ajzen and Fishbein (1980), will in turn influence the social pressures acting on behavior, and reduce impediments to the psychiatric patients' reintegration with society.

Psychiatric Attitude Assessment Techniques

While community and patient attitudes towards psychiatric illness, institutions and staff unquestionably remains a topic of considerable merit, few studies seem to have utilized a single consistent method for assessing these attitudes. Many studies have relied on unstructured interview techniques (Freeman, 1961) making comparisons across studies difficult and tenuous. The various standardized methods that exist have been criticized on a number of counts.

The Psychiatric Attitudes Battery (PAB)(Reznikoff, Brady and Zeller, 1959) is an amalgam of several different subtests using various strategies to provide a single global psychiatric attitude measure, as well as those specific to psychiatrists, hospitals and treatment. It was designed to "tap both conscious and unconscious attitudes" and utilizes tests that are both projective (The Picture Attitudes Test) and more objective (The Souelem Attitude Scale). Unfortunatley many of the questions use obsolete terminology or structure (such as 'Mental hospitals are evil and sinful.', 'A mental hospital is probably the best place for a mentally sick person.', 'Mental hospitals are houses

of living death.') and outdated illustrations (Mountain, 1985).

The Custodial Mental Illness Ideology Scale (Gilbert and Levinson, 1956) uses 20 Likert scale statements addressing mental illness and patient care. Individual attitude scores are placed along a single continuum with custodialism and humanism at opposite poles. Rabkin (1972) states that both poles can be broken down into constituent components, and that maintenance of a single continuum in this instance is inappropriate. Wahl, Zastowny and Briggs (1980) performed a factor analysis on the scale and found a third factor (which they termed Paternalism) while the original Custodialism and Humanism factors appeared to be more independent than opposite poles of a single continuum.

The Opinions About Mental Illness Questionnaire (Cohen and Struening, 1962) is perhaps the most frequently used scale (Rabkin, 1972). A 51 item Likert opinion scale, it provides 5 seperate scores for each respondent. These scores represent the individuals' support for the 5 attitude dimensions (Authoritarianism; Benevolence; Mental Hygiene Ideology; Social Restrictiveness; Interpersonal Etiology). This scale has been criticized however, for inadequately covering the social-psychological perspective of mental illness (Rabkin, 1972; Morrison, 1976). This modern perspective emphasizes the complex social-psychological etiologies of illness and treatment. More recently, a factor analytic reexamination of the scale found several 'substantial' deviations in factor structure and scoring. While two of the original five factors were replicated (Mental Hygiene Ideology and Interpersonal

Etiology), three new factors emerged, effectively redistributing the items from the original three scales (Wahl, Zastowny and Briggs, 1980).

Purpose

The purpose of the present study was to develop a psychiatric attitude measure with content relevent to the current clinical status and political ideology of psychiatry. Furthermore, the aim was to develop an instrument according to a rigorous method of scale construction such that psychometric properties would be optimal. To this end Jackson's (1984) sequential system for personality scale development was followed.

METHOD

Subjects

For the purpose of scale construction, item assessment and test reliability information, 145 Lakehead University students, 20 Lakehead Psychiatric Hospital outpatients, 35 Community College students and 10 Registered Nurses completed the questionnaire (mean age approximately 22; approximately 145 females, 65 males).

Procedure

Scale development parallels the procedure outlined by Jackson (1984) for The Personality Research Form and focuses on the development of reliability and construct validity, leaving predictive validity for future work.

1) A careful study of the relevant research works on attitude theory, and research as well as reference works on attitudes of and towards psychiatric patients to psychiatric illness, hospitalization and treatment was undertaken. This included the examination of previously constructed tests for their orientation, construction, and method of investigation (ie. the scales used). This information was then used to formulate definitions of the attitude dimensions consistently referred to in the literature. This a priori analysis suggested three dimensions which the author defined as follows:

Restrictive Control(RCtr);

This attitude towards psychiatric illness and treatment is characterized by an authoritarian view of psychiatric patients. Thus, patients with psychiatric disorders are viewed as different from and inferior to normals. Their illness is perceived as a weakness and their behavior as unpredicatbly dangerous. Consistent with this view, treatment and management of such patients is based on control. Patients should be segregated in a secure environment, and treatment imposed to render them safer and more adaptive.

Protective Benevolence(PBen);
This attitude toward psychiatric illness and treatment is characterized by a charitable concern for psychiatric patients. Thus, patients with psychiatric disorders are viewed as unfortunate victims who need special consideration and support. They are perceived as unpredictable and potentially dangerous, but with some sympathy for diminished responsibility for their actions. Consistent with this view, treatment and management is based upon kindness towards unfortunates. However, this attitude is more patronizing than enlightened. Management and treatment continue to exercise considerable control, ostensibly for the patients' own welfare.

Humanistic(Hum);
This attitude toward psychiatric illness and treatment is characterized b an appreciation of the multiple and complex factors contributing to psychiatric difficulties. Thus, patients with psychiatric disorders are viewed as individuals suffering from an illness which limits their ability to function adaptively. There is

> an awareness of unpredictablity and possible danger, but without sweeping generalizations. Consistent with this view, treatment and management is based upon multiple professional approaches aimed at community reintegration. Some control may be inevitable, but always with due concern for patient rights and dignity.

2) Next, a large pool of items,(RCtr-61;PBen-40;Hum-39), was developed. Each item was written such that it's content was relevant to the target definition of the attitude dimension in question. As well, the questions covered five content areas; patients, illness, treatment, hospitals and staff. This, it was believed, would allow for a broad coverage of the three proposed dimensions, directed towards the future development of three global scales of measurement. Once generated, these items were examined independently by two reviewers (one had an M.A. degree and eight years experience in the mental health field; the other had a Ph.D. and 12 years experience; 5 of them within a psychiatric setting) who suggested revision, elimination or acceptance. The accepted/rewritten items were then compiled into an item battery, with approximately one-half of the True/False items directionally reversed. Jackson's (1984) Desirablity scale was also included such that items could later be checked for their tendency to elicit 'desirable responding' trends. The items were randomly ordered. The item batteries were further vetted by three psychiatrists and one vocational-rehabilitation officer with experience with community attitudes towards psychiatry and psychiatric patients. Some items were again rewritten and included in a final battery.

3) This final battery, which included 140 attitude and 16 desirability items (156 total) was then administered to the

large subject samples already described.

4) The items were then examined for the frequency of directional responding, to identify items exhibiting variation in response.

5) A Factor analysis was performed to examine the psychometric support for the theoretical definition of the dimensions. It was repeated using various rotations and specifying a limit of five factors (one for each of the theoretically defined dimensions, including Jackson's (1984), plus an additional one for error variance). These analyses were then repeated, deleating items which were answered in a single direction 12.5% and 25% of the time (noted within the present text as absolute values; ¶12.5%¶ and ¶25%¶). Dimensional-item content was reexamined accordingly. Items correlated to a factor with an absolute value <.30, were eliminated.

6) Split half and alpha reliability estimates were then calculated for each scale, to provide measures of internal reliability.

Results

The battery was given to 210 subjects and the individual items were examined for the frequency of directional responding.

When the original 156 items were pared for showing a variability in response of less than¶12.5%¶, 115 items remained for further analysis. When items were eliminated for showing a variation in response of less than ¶25%¶, 74 items remained in

the battery for further investigation. The original item distributions for the proposed dimensions, as well as the definitions subsequent to item elimination, can be found in Table 1.

Principal Components Analyses

A principal components factor analysis was performed on all the items included in the battery using varimax rotation. Fifty-three principal components factors emerged, accounting for 76.2% of the total variance. Examination of the scree plot suggests a flattening after 10 factors (accounting for 29.9% of the total variance). Twenty-four items account for 50.2% of the total variance. These factors proved too numerous to allow for adequate theoretical conceptualization. The Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy was equal to .33725 (unacceptable). The Bartlett test of Sphericity was incalculable. A principal components factor analysis was then performed using various rotations and specifying a limit of five factors. The nonrotated, varimax and quartimax rotations were chosen during the analyses as providing the most meaningful and statistically clean information. Five factors account for 19.9% of the total variance in the item battery. (Refer to Table 2 for Item-Factor loadings).

When a principal components factor analysis was performed on the items showing a variability of response greater than ¶12.5%¶, forty principal component factors emerged. Twenty-two factors account for 51% of the total variance. The scree plot suggests a flattening after eight factors (27.6% of the total

variance). The KMO measure of sampling adequacy was equal to 0.45158 (unnacceptable), while the Bartlett test of sphericity was significant to five decimal places. A principal components factor analysis was also performed using varimax and quartimax rotations and specif ing a limit of five factors. Five factors account for 20.5% of the total variance of the items included in these analyses (Refer to Table 1 for theoretical dimension- item distribution).

When a principal components factor analysis was performed on the items showing a variability of response greater then an absolute value of 25%, 28 principal component factors emerged. Seventeen factors account for 51.1% of the total variance. The scree plot suggests a flattening after 12 factors, accounting for 41.1% of the total variance. The KMO measure of sampling adequacy was 0.58350 (mediocre), while the Bartlett test of sphericity was significant to five decimal places. As above, a principal components factor analysis was performed using varimax and quartimax rotations and specifying a limit of five factors. Five factors account for a total variance of 23.3% of the items included in these analyses(Refer to Table 1 for the theoretical item-dimension distribution).

Reliabilities

Reliability analyses were performed on items as they were included in the original theoretical scale definitions, as well as for their inclusion in the mathematically defined factors obtained with the unrotated and quartimax rotated factor analyses. Two measures will be reported, the Guttman split-half

and Alpha estimates of reliability.

For the theoretically defined scales, the Guttman split-half measures of reliability ranged from .4308 (Jackson's(1984) Desirability scale) to .6341 (on the Protective Benevolence scale). Similarly the alpha estimates ranged from .3834 to .6731 respectively. (Refer to Table 3).

For the factors derived by the unrotated factor analyses (limited to five factors) performed on all items, the Guttman split-half estimates ranged from .0205 (factor5) to .5880 (factor1). The alpha estimates ranged from .0418 (factor4) to .6965 (factor1). For the factors derived from similar analyses performed on the items with a variability of response greater than ¶12.5%¶, the Guttman split -half estimates ranged from .0828 (factor4) to .5862 (factor3). The alpha estimates range from .0424 (factor5) to .6093 (factor3). Finally, for the factors derived from the unrotated factor analyses performed on items with a variablity in response greater than ¶25%¶, the Guttman split-half estimates range from -.0852 (factor5) to .4910 (factor2).

For the factors derived by a quartimax rotated principal components factor analysis (limited to five factors) performed on all items, the Guttman split-half estimates ranged from 0.0796 and 0.0962 on the first and third factors, respectively, to 0.6311 on the fourth factor. The alpha estimates ranged from 0.0081 on the third factor, to 0.6419 on the fourth factor. For the factors derived by a quartimax rotated principal components factor analysis performed on the items with a variability of

response greater than ¶12.5%¶, the Guttman split-half estimates ranged from -.2025 (factor5) to .5783 (factor3). The alpha estimates ranged from .0424 (factor5) to .6362 (factor1). Finally, for the factor scales derived by a quartimax rotated principal components factor analysis on the items with a variability of response greater than ¶25%¶, the Guttman split-half reliability estimates range from -.3940 (factor2) to -.6885 (factor5). The alpha estimates range from -.0804 (factor2) to .5365 (factor4).

A variation of the Differential Reliability Index (DRI), used by Jackson (1984), was defined for items of the RCtr factor obtained by quartimax rotation of the principal component factor analysis of the ¶25%¶ items. In brief, this index is designed to suppress scale desirability by eliminating items which are highly correlated with the desirability factors. Items were ranked according to the difference between the correlation to their own factor, and their correlation to the desirability factor. The top 15 items for the dimension were then maintained, comprising the final dimension. The DRI was pursued with only the single factor, as it alone was large enough to warrant further item elimination at this stage of the analyses.

Discussion

As previously mentioned, the item pool was developed such that five content areas were examined relative to the three theoretical attitude dimensions of interest. The rationale was that the attitude dimensions would be revealed through people's

views about various aspects of psychiatric care (eg. illness, treatment, institutions etc.). Necessarily, those items which seemed to provide little information were eliminated. Consequently items were eliminated if they were endorsed in the same direction by a large proportion of the subject sample. Thus items exhibiting greater variation in response were kept, as they would potentially provide more information. There were two levels of such item elimintion, based on the frequency with which they were endorsed(12.5% and 25%).

Factor analyses were performed on all three levels of items from the battery (full, ¶12.5%¶ and ¶25%¶), and became the key method of examining the scale definitions. As the respondent to item ratio increased as items were eliminated, the factor analyses also became progressively more sound (Tinsley and Tinsley (1987)).

Factor Descriptions

The first factor which emerged from each analysis appeared similar to the Restrictive Control (RCtr) dimension in that a high percentage of items from this dimension loaded on these factors. While lower percentages of items from the other dimensions also appeared in these factors, it was found that they were consistent with the definition of the RCtr dimension. (This smearing of item definitions through the dimensional distributions will be further addressed below.) In general, these were the most reliable factors.

In five out of nine analyses (5/9), variants of the Protective Benevolence (PBen) dimension appeared as the second

factor. These factors were comprised of moderately toned (less authoritarian) items from the original RCtr dimension, with items from the PBen dimension adding the paternal yet patronizing tone of the original definition.

Other factors which emerged as the second factor were described either as 'Personal Pathology' or 'People Pathology'. These factors were comprised mainly of items from Jackson's (1984) Desirability scale, combined with items from the RCtr dimension, all oriented in an 'undesirable' direction.

The third factors to emerge (again, five out of nine analyses) were variations of the Humanitarian (Hum) dimension. Comprised of items from all three original dimensions, the items from the RCtr and PBen dimensions generally describe treatment and hospital inadequacies (eg. no.123. "Psychiatric treatment should be more directed towards preventing psychiatric illness"; an item originally designed as a negatively oriented RCtr item) and only twice is one of these items inconsistent with the original attitudinal definition. Two (of the five) Hum dimensions appear as two seperate factors (third and fourth). In these instances, one factor describes inadequacies in the present treatment system, while the other describes ideological ideals (eg. factors 3 and 4 of the quartimax rotated factor analyses for the ¶25%¶ items).

The other factors which emerged as third factors are quite divergent from each other. One (Humanistic Hospital & Idealism) resembles a restricted Hum dimension in that the humanistic ideals are directed solely towards hospital issues. The

'Personal Pathology and Psychological Cynicism' (Psychological Cynicism here being a cynical attitude towards Psychology as a science and a profession) factor is similar to some of the 'undesirability' factors previously described. The remaining two are even more difficult to conceptualize, with one defying description completely.

As with these latter third factors described above, and with the exception of the Hum factors also previously described, the fourth factors are also difficult to adequately define. Described as 'Negative Psychiatric Desirability' factors ('undesirable' attitudes to the psychiatric domain), they may prove valuable in the future development of a 'Psychiatric Desirability' scale.

The fifth factors are largely desirability factors, frequently being a mixture of Jackson's (1984) Desirability scale items and other scale items.

Factor-Scale Integrity

While no dimension remained 'pure' as originally defined, factor support for all three dimensions emerged at some point in the analyses, thereby supporting a certain theoretical consistency. Despite appearing as independent factors in the analyses, the RCtr and Hum factors present almost as polar opposites in item composition. Each factor frequently contains items from the original theoretical definition of the other, but in some negative fashion (ie. negative correlations with positively worded items, and positive correlations with negatively worded items). The implication of this for item

rewriting is discussed below.

The Protective Benevolence dimension is possibly the weakest in it's expression as a factor. Frequently it manifests with a large body of RCtr items, with smaller numbers of PBen items providing the patronizingly-paternal 'tone' of the dimension. Thus the two dimensions may differ in their expression as factors by virtue of only four items (items 36, 47, 49 and 69 when comparing the ¶12.5%¶ quartimax rotated factor one, and the all item, quartimax rotated factor two).

Examination of the factor analyses with respect to the validity of investigation (greater respondant to item ratio), definitional integrity of the factors and their corresponding reliabilities, suggests that the quartimax rotated principal component factor analysis of the ¶25%¶ items provides the most potentially useful aggregate of items for later scale development.

The DRI was pursued with only the RCtr factor, as it alone was large enough to warrant further item elimination. With the elimination of five items from that factor, as well as of Jackson's (1984) Desirability scale, forty items encompassing four factors remain. Statistically, these are items with the highest definitional integrity and reliability and would serve as a core set of items for subsequent research.

Limitations

The original intention of the present study was to develop a battery of items that adequately represented three theoretical attitude dimensions. Hence items were written that covered each

of five content areas for each of the three dimensions in question. Although this strategy initially seemed reasonable and advantageous, in the long run it diluted the factor content by virtue of having items which were too diverse in nature. Some of the elements proved extreme (eg. item26 of the RCtr scale) while others were much less so (eg. item81 RCtr scale).

Subjects on occassion expressed their inability to consistently respond to items due to the unspecified target population. For instance, while one respondant might answer a question, "Psychiatric patients...." with regards to an individual suffering from a form of neuroses, another might respond considering an individual experiencing a manifest psychoses, as questions did not specify this. While this had been a deliberate attempt to examine the"stereotypic" patient, it largely proved too disconcerting for the present sample (incidentally, patients themselves apparently had little difficulty with this). Similarly, responses for a single respondant may be inconsistent throughout a single questionnaire.

As is obvious from the analyses, much more variance arose than could be readily accounted for by the theoretical scales (incl. Jackson's (1984) Desirability scale). In fact, these factors when combined frequently accounted for only a small percentage of the total variance. While selecting only the first five factors for investigation helped to reduce the overload of information (as well as the number of items), it doesn't negate the possibility that valid attitudinal dimensions

were overlooked as error variance and discarded.

This is partially illustrated when the Hum dimension twice manifested as two seperate factors. This indeed may also have been the case with other factors, which might have been so splintered as to be missed in the authors interpretation or arbitrary examination of the first five factors.

As experimentor biases may have influenced the neglect of factor information, so may they have influenced the description of the factors found. Desirability and expectancy likely played a certain role in helping conform factors to scale definition.

One of the more significant influences on the excessive error variance, is likely the relatively small number of subjects to variables. While Tinsley and Tinsley (1987) suggest that the number of subjects necessary for precision in defining factors in a factor analysis is also influenced by the number of variables intended to measure a given factor, they cite research recommending 5-10 subjects per variable up to 300 subjects. When the sample increases beyond 300 respondents, then this ratio becomes less crucial. The present study, with a sample of some 210 respondents, falls short of both the suggested ratio as well as the 300 mark. Even with a significant number of items eliminated for minimal variance in response (82 items eliminated in the ¶25%¶ analyses), the ratio just approaches 3. In fact only during this latter set of analyses did the KMO measure of sampling adequacy approach a 'mediocre' level.

Inherent in the limited size of the sample used to investigate the battery of items is it's limited representativeness. With the possible exception of the psychiatric patients interviewed, all of the sample were involved in education at the college or university level and likely represent a bias in education. Consequently, those involved in the study may have had a greater understanding of psychiatric illness and treatment than the public 'at large' thereby influencing their responses to the items and narrowing their representativeness.

Future Research

Future research must take into consideration the concern of scale specificity. In the present study, the attempt to encompass various aspects of the dimensions served in part to obfuscate their integrity. This has several implications; 1) a narrower range of items which are minor variations of each theoretical dimension and examine a single content area and 2) a greater alertness to the wording of items such that they do not form a negative variant of another dimension is required.

Similarly the target group in question must be specified if questions are to be directed towards the perceived reliability of different groups of psychiatric patients.

Subject samples which are more representative of the public at large would assist in sampling the more stereotypical attitudes towards the psychiatric illness domain commonly associated with the less educated. Also, as one increases the respondant to item ratio, factor definition improves as the

variance attributable to error decreases. Hence larger subject smples would be required.

The biases introduced into the examination and defintion of factors introduces error and can be reduced in future research by utilising several individuals, possibly blind to study goals, in this task.

Ultimately the development of a set of items which could be randomly imbedded within the larger group of items and designed to assess the degree to which desirability possibly influences a respondants response pattern would be beneficial. This 'Psychiatric Desirability' scale will replace Jackson's (1984) Desirability scale in the present study, and will be designed to blend in with the style with which the other items have been written.

Of closing interest is the observation that the most negative statements regarding psychiatric patients, while infrequently endorsed, were endorsed by patients themselves. Whether this reflects differences in experience with and or exposure to psychiatric patients, treatment and hospitalization, a desirability factor of some kind, or some other influence is unfortuneately unknown.

The present study suggests a set of 40 items which may prove valuable in the study of attitudes towards psychiatric patients, hospitalization and treatment, despite inadequacies which limit the utility of strong conclusions. However, areas demanding increased control for further examination of the validity and reliability of any set of items have been

discerned, as well as the possibility that these areas are in part responsible for the failure of past inventories when applied to populations outside of the psychiatric setting. Hopefully, this kind of assessment device will provide valuable information regarding people's attitudes to the domain of psychiatric illness, such that educational criterion and services can be established to reduce the negative impact which these attitudes appear to have on treatment.

As future studies of the dimensions discussed herein will also likely be of a confirmatory nature, LISREL analyses should be examined as being more appropriate than the factor analyses used in the present study. The number of items per domain or scale must also be made equivalent to one another, in order that biases of unequal weighting can be avoided.

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TABLE I

ITEM AFFILIATION TO THEORETICAL SCALE

Full Battery

estrictive Control: 3,4,6,9,10,11,19,20,21,22,23,25,26,27,30,32,36,
37,38,39,41,47,51,52,56,57,61,67,68,69,71,76,80,
81,83,84,88,94,95,97,98,100,102,108,110,111,115,
117,122,123,128,129,132,134,137,138,140,143,149,
151,152.

rotective Benevolence: 1,2,7,16,17,18,24,29,31,40,43,46,49,53,62,63,
65,70,73,74,78,86,87,90,91,92,99,101,106,109,
114,118,119,120,124,126,133,148,153,155.

lumanistic: 5,8,12,13,15,33,35,42,44,48,50,54,55,58,59,60,64,66,75,79,
85,89,93,104,105,107,112,116,121,127,130,135,136,139,141,
144,146,150,156.

12.5 - 87.5

lestrictive Control: 3,4,6,10,11,19,21,22,26,36,39,47,51,52,56,61,67,
69,71,76,80,81,94,95,97,102,108,111,115,117,123,
128,129,132,137,138,140,143,149,151,152.

rotective Benevolence: 2,16,17,18,24,29,43,46,49,53,63,65,73,74,78,
86,87,90,91,92,99,101,106,109,114,118,119,120,
124,126,153,155.

lumanistic: 5,8,13,15,35,42,44,48,50,59,60,64,66,75,79,89,104,105,107,
121,127,130,135,136,139,150,156.

25 - 75

lestrictive Control: 3,6,10,11,19,21,26,36,47,51,52,61,69,71,80,81,
94,95,97,102,115,117,123,128,132,137,138,140,143,149.

rotective Benevolence: 2,17,18,43,46,49,53,63,65,73,78,86,90,92,106,
114,119,120,124,126.

lumanistic: 5,8,13,15,44,59,60,75,79,89,105,121,127,130,135,136,139,150.

TABLE II

ITEM LOADINGS: FACTOR I

ANALYSIS: ALL ITEMS

NONROTATED	VARIMAX	QUARTIMAX
118 (.60191)	151 (.60607)	37 (.65547)
98 (.59303)	92 (.56705)	38 (.57145)
110 (.59099)	97 (.52152)	30 (.55232)
93 (-.51809)	138 (.51759)	129 (.54500)
108 (.51620)	94 (.49851)	68 (.53499)
57 (.51284)	120 (.48721)	93 (-.49191)
30 (.50652)	90 (.45995)	110 (.48996)
129 (.49542)	140 (.45983)	25 (.47574)
38 (.48952)	89 (-.45032)	57 (.46845)
37 (.48839)	75 (-.44358)	54 (-.46712)
100 (.46480)	111 (-.43960)	40 (.46222)
116 (-.46370)	49 (.43641)	27 (.46082)
84 (.44456)	118 (.42520)	41 (.44988)
27 (.44168)	155 (.40883)	108 (.43516)
94 (.43287)	105 (-.40668)	24 (.40762)
41 (.42816)	44 (.40123)	134 (.39491)
25 (.42520)	106 (.39707)	33 (.38920)
68 (.40606)	128 (.39346)	153 (-.37689)
40 (.40439)	81 (.38964)	55 (-.37604)
90 (.40205)	59 (-.37850)	112 (-.37419)
55 (.39084)	80 (-.36828)	56 (-.37050)
134 (.37997)	117 (.36068)	19 (.34307)
33 (.37586)	15 (-.35322)	66 (.33584)
111 (-.37378)	17 (.34748)	9 (.33073)
155 (.37275)	4 (.32144)	23 (.32948)
120 (.36833)	51 (.31630)	62 (-.32299)
121 (-.36800)	52 (.31440)	116 (-.31739)
54 (-.35619)	11 (.30931)	63 (.31569)
102 (.34976)	116 (-.30369)	79 (-.31073)
9 (.34702)	87 (.30169)	109 (-.30642)
19 (.34186)	65 (.30045)	148 (-.30119)
15 (-.33820)		
63 (.33621)		
28 (.32711)		
133 (.32700)		
23 (.31629)		
32 (.31598)		
106 (.31362)		
24 (.30175)		

ITEM LOADINGS:FACTOR II

ANALYSIS: ALL ITEMS

NONROTATED	VARIMAX	QUARTIMAX
151 (.49813)	37 (.63131)	151 (.61037)
97 (.46371)	38 (.54109)	92 (.56504)
105 (-.45618)	30 (.49910)	97 (.51915)
75 (-.42693)	129 (.49667)	138 (.51552)
87 (.42473)	68 (.48711)	94 (.48611)
81 (.41793)	40 (.46559)	120 (.48272)
92 (.40820)	27 (.43339)	140 (.45747)
80 (-.40303)	54 (-.42927)	90 (.45414)
49 (.39470)	41 (.41900)	89 (-.44996)
44 (.38864)	56 (-.41682)	75 (-.44612)
138 (.38890)	55 (-.41364)	49 (.43901)
109 (.38583)	57 (.40660)	111 (-.43109)
140 (.38559)	66 (.38511)	118 (.42149)
96 (.38423)	24 (.38328)	105 (-.41412)
89 (-.34467)	33 (.36832)	155 (.40771)
115 (-.33761)	62 (-.35742)	44 (.40591)
112 (.33267)	112 (-.33454)	106 (.39472)
17 (.33252)	29 (.33377)	128 (.39083)
65 (.32627)	23 (.31608)	81 (.38996)
59 (-.31487)	9 (.31353)	59 (-.38310)
128 (.31442)	153 (-.31330)	80 (-.37922)
	109 (-.30852)	117 (.35482)
	19 (.30851)	15 (-.35644)
		17 (.35207)
		52 (.32316)
		4 (.32234)
		51 (.32181)
		87 (.31198)
		11 (.31066)
		65 (.30401)

ITEM LOADINGS: FACTOR III

ANALYSIS: ALL ITEMS

NONROTATED	VARIMAX	QUARTIMAX
135 (.59168)	154 (.61816)	85 (.63499)
60 (.38472)	142 (.55607)	70 (.56503)
137 (.38117)	131 (.52052)	98 (-.49788)
142 (.37089)	45 (.51589)	99 (.46868)
7 (.36709)	28 (.45851)	100 (-.45754)
123 (.36689)	152 (.44869)	88 (.33406)
35 (.33596)	25 (.40991)	123 (.32680)
18 (.33249)	103 (.40545)	
104 (.31471)	96 (-.39844)	
130 (.31183)	134 (.39724)	
107 (.31101)	72 (-.39084)	
99 (.30585)	34 (-.37676)	
	14 (-.35022)	
	133 (.33564)	
	125 (-.33409)	
	77 (.32958)	
	84 (.30227)	

ITEM LOADINGS: FACTOR IV

ANALYSIS: ALL ITEMS

NONROTATED	VARIMAX	QUARTIMAX
85 (-.56768)	85 (.63315)	135 (.45956)
70 (-.40025)	70 (.56683)	104 (.39197)
149 (.33770)	98 (-.53354)	60 (.37982)
124 (.33097)	100 (-.47753)	137 (.36609)
	99 (.47750)	7 (.36171)
	93 (.46442)	61 (.36003)
	110 (-.45312)	124 (.35700)
	108 (-.37725)	115 (.33307)
	88 (.35752)	149 (.32791)
	123 (.34767)	86 (.32043)
	107 (.33283)	136 (.31796)
		71 (.31745)
		107 (.31489)
		127 (.31332)
		8 (.31039)
		114 (.30154)

ITEM LOADINGS: FACTOR V

ANALYSIS: ALL FACTORS

NONROTATED	VARIMAX	QUARTIMAX
103 (-.45756)	135 (.47191)	135 (.45956)
131 (-.39082)	104 (.39590)	104 (.39197)
29 (.35755)	60 (.38681)	60 (.37082)
154 (-.35018)	137 (.36509)	137 (.36609)
77 (-.34831)	124 (.36417)	7 (.36171)
56 (-.34563)	7 (.35116	61 (.36003)
72 (.32671)	61 (.34990)	124 (.35700)
45 (-.31996)	149 (.33604)	115 (.33307)
66 (.30984)	115 (.33011)	149 (.32791)
	86 (.31596)	86 (.32043)
	136 (.31358)	136 (.31796)
	71 (.31126)	71 (.31745)
	127 (.30770)	107 (.31489)
	79 (.30377)	127 (.31332)
	114 (.30150)	8 (.31039)
		114 (.30154)

ITEM LOADING: FACTOR I

ANALYSIS: ITEMS 12.5-87.5% FREQUENCY

NONROTATED	VARIMAX	QUARTIMAX
151 (.60200)	151 (.60089)	151 (.62853)
92 (.55654)	92 (.53194)	92 (.54516)
118 (.55637)	97 (.50858)	138 (.50928)
138 (.51353)	138 (.48354)	97 (.49663)
94 (.48846)	49 (.46670)	89 (-.46709)
90 (.48542)	140 (.45863)	120 (.46402)
120 (.48135)	89 (-.45047)	140 (.45420)
89 (-.45984)	81 (.44030)	90 (.44407)
155 (.44033)	75 (-.43639)	118 (.43971)
97 (.43838)	80 (-.43166)	94 (.43901)
140 (.42739)	120 (.42472)	75 (-.43290)
49 (.42463)	44 (.42407)	59 (-.41446)
106 (.42291)	105 (-.42282)	44 (.40836)
111 (-.40892)	59 (-.42001)	106 (.40554)
75 (-.40681)	90 (.39754)	105 (-.40273)
59 (-.38887)	117 (.38819)	155 (.400836)
57 (.37499)	51 (.38152)	81 (.39356)
15 (-.36742)	128 (.36926)	80 (-.39185)
44 (.36432)	69 (.36465)	117 (.39091)
128 (.36428)	106 (.36452)	111 (-.38353)
117 (.36156)	47 (.36266)	128 (.38289)
105 (-.35999)	17 (.36153)	51 (.37210)
80 (-.35274)	155 (.35886)	15 (-.36810)
17 (.33583)	111 (-.35766)	17 (.35820)
52 (.33408)	65 (.35522)	47 (.34921)
4 (.33291)	15 (-.35442)	52 (.34541)
36 (.33063)	87 (.35352)	69 (.34407)
81 (.32761)	52 (.35069)	11 (.33489)
127 (-.32693)	115 (-.33869)	87 (.32789)
11 (.32101)	16 (.31970)	4 (.32554)
69 (.31796)	11 (.31042)	65 (.30455)
143 (.31701)	126 (.30039)	36 (.30080)
102 (.31096)		
121 (-.31379)		
64 (-.31011)		
47 (.30934)		
63 (.30329)		

ITEM LOADING: FACTOR II

ANALYSIS: ITEMS 12.5-87.5% FREQUENCY

NONROTATED	VARIMAX	QUARTIMAX
28 (.46419)	154 (.60207)	154 (.59877)
154 (.46175)	142 (.56301)	142 (.56345)
45 (.45450)	45 (.53272)	45 (.53202)
108 (.43905)	131 (.52941)	131 (.52846)
142 (.41421)	28 (.50860)	28 (.50811)
35 (.41367)	152 (.44571)	152 (.44540)
152 (.40050)	118 (.41618)	34 (-.42115)
34 (-.37895)	34 (-.41589)	14 (-.38600)
129 (.36968)	14 (-.38413)	72 (-.34910)
14 (-.36269)	129 (.35426)	129 (.34400)
131 (.36144)	72 (-.35065)	35 (.33973)
153 (-.34422)	48 (-.33973)	48 (-.33913)
48 (-.34253)	77 (.32439)	77 (.32785)
115 (.33349)	102 (.31610)	125 (-.31369)
19 (.32362)	125 (-.30863)	102 (.30530)

ITEM LOADING: FACTOR III

ANALYSIS: ITEMS 12.5 -87.5% FREQUENCY

NONROTATED	VARIMAX	QUARTIMAX
60 (.52259)	60 (.47639)	60 (.49760)
135 (.51258)	135 (.46983)	135 (.48088)
104 (.43583)	104 (.41377)	104 (.43240)
123 (.43096)	137 (.40183)	137 (.40787)
137 (.42417)	86 (.37006)	123 (.37438)
119 (.33341)	61 (.36668)	124 (.35766)
73 (.31890)	124 (.36302)	86 (.35280)
79 (.31823)	73 (.35228)	61 (.35226)
99 (.31158)	35 (.34404)	73 (.35101)
114 (.30913)	8 (.34255)	114 (.33739)
124 (.30878)	114 (.34233)	115 (.32952)
18 (.30786)	136 (.32415)	136 (.32783)
107 (.30030)	2 (.31028)	2 (.30962)
		127 (.30792)
		119 (.30489)

ITEM LOADING: FACTOR IV

ANALYSIS: ITEMS 12.5-87.5% FREQUENCY

NONROTATED	VARIMAX	QUARTIMAX
29 (.45757)	56 (-.48930)	56 (-.48860)
103 (-.45065)	109 (-.45617)	109 (-.46713)
56 (-.41444)	22 (-.41997)	22 (-.42993)
8 (.38546)	29 (.41228)	29 (.41216)
109 (-.34097)	108 (.40106)	108 (.39272)
86 (.33630)	19 (.37340)	19 (.37120)
22 (-.33207)	103 (-.36956)	8 (.36725)
	123 (-.35241)	103 (-.36079)
	79 (-.34122)	79 (-.31724)
	66 (.32817)	66 (.31695)
	153 (-.30403)	

ITEM LOADING: FACTOR V

ANALYSIS: ITEMS 12.5-87.5% FREQUENCY

NONROTATED	VARIMAX	QUARTIMAX
149 (.49790)	147 (.45161)	149 (.45928)
147 (.45483)	130 (-.44166)	147 (.45471)
26 (-.39660)	149 (.44098)	130 (-.42981)
24 (-.39087)	145 (.40127)	145 (.37906)
130 (-.37332)	94 (.38728)	26 (-.37735)
145 (.34378)	24 (-.33746)	24 (-.37262)
150 (.30116)	26 (-.32962)	150 (.30513)
	150 (.32268)	
	36 (.31298)	

ITEMS LOADING: FACTOR I

ANALYSIS: ITEMS 25- 75% FREQUENCY

NONROTATED	VARIMAX	QUARTIMAX
92 (.57416)	97 (.52960)	92 (.54530)
138 (.53641)	92 (.52116)	97 (.53681)
97 (-.49455)	49 (.47081)	49 (.48001)
120 (.48907)	80 (-.47072)	80 (-.47084)
94 (.47787)	26 (.46059)	81 (.45819)
90 (.47760)	81 (.46021)	26 (.43640)
49 (.47025)	44 (.42756)	140 (.43547)
140 (.44594)	52 (.42255)	44 (.43164)
80 (-.41298)	140 (.42131)	117 (.42260)
106 (.41065)	117 (.41586)	105 (-.42131)
44 (.41049)	105 (-.41487)	52 (.41729)
75 (-.40251)	69 (.39713)	138 (.40977)
59 (-.39799)	51 (.39067)	51 (.40073)
105 (-.39754)	65 (.39064)	59 (-.40028)
81 (.39524)	59 (-.38993)	89 (-.40008)
51 (.39180)	17 (.38369)	69 (.39747)
128 (.38698)	89 (-.37032)	17 (.38756)
117 (.38224)	128 (.35422)	65 (.38601)
15 (-.37996)	47 (.35057)	128 (.36920)
17 (.35332)	53 (.30179)	47 (.35705)
69 (.34524)		
52 (.32536)		
127 (-.32503)		
47 (.32438)		
11 (.32418)		
36 (.30048)		

ITEMS LOADING: FACTOR II

ANALYSIS: ITEMS 25-75% FREQUENCY

NONROTATED	VARIMAX	QUARTIMAX
135 (.56991)	94 (.57775)	94 (.55599)
137 (.52495)	123 (-.48842)	123 (-.50972)
60 (.45472)	90 (.46683)	143 (.43174)
61 (.40578)	143 (.44194)	45 (.42638)
115 (.39479)	127 (-.42255)	127 (-.40853)
124 (.36053)	45 (.41768)	121 (-.40461)
8 (.34909)	120 (.41343)	120 (.38023)
136 (.33121)	121 (-.41060)	106 (.36965)
86 (.32718)	138 (.41025)	15 (-.32616)
114 (.32461)	106 (.39292)	36 (.30840)
139 (.30448)	15 (-.34728)	
	36 (.32911)	

ITEMS LOADING: FACTOR III

ANALYSIS: ITEMS 25-75% FREQUENCY

NONROTATED	VARIMAX	QUARTMAX
45 (.40369)	8 (.49516)	8 (.49883)
26 (-.38829)	114 (.48008)	114 (.47742)
130 (-.37499)	86 (.45758)	86 (.45664)
123 (-.35997)	19 (.44423)	19 (.44145)
131 (.31494)	75 (.42063)	75 (.42842)
65 (-.31313)	115 (.38128)	115 (.39012)
150 (.30540)	60 (.36511)	60 (.36756)
	61 (.36447)	61 (.36171)
	73 (.36348)	131 (.31255)
	131 (.31162)	124 (.31029)
	124 (.30792)	

ITEMS LOADING: FACTOR IV

ANALYSIS: ITEMS 25-75% FREQUENCY

NONROTATED	VARIMAX	QUARTIMAX
2 (-.45279)	135 (.60096)	135 (.59962)
149 (-.41549)	2 (.57897)	2 (.57943)
19 (.40062)	79 (.44704)	79 (.44566)
79 (-.38237)	149 (.43984)	149 (.44231)
3 (-.33061)	3 (.41423)	3 (.41557)
	137 (.41377)	137 (.41004)
	5 (.32482)	5 (.32537)

ITEMS LOADING: FACTOR V

ANALYSIS: ITEMS 25- 75% FREQUENCY

NONROTATED	VARIMAX	QUARTIMAX
113 (.48294)	147 (.57565)	147 (.57646)
147 (.45786)	113 (.50214)	113 (.50202)
95 (-.37336)	130 (-.47051)	130 (-.47135)
143 (-.30967)	139 (-.40708)	139 (-.40585)
	145 (.39074)	145 (.39346)
	95 (-.38826)	95 (-.38444)
	108 (.33746)	150 (.34168)

TABLE III

RELIABILITY ESTIMATES

Alpha Estimates

A) Non-Rotated Factor Analyses:

Items	Factor 1	2	3	4	5
All	.6965	.3370	.5916	.0418	.1850
12.5-87.5	.5662	.4064	.6093	-.0659	.0424
25-75	.5142	.5655	.1858	.3425	-.1194

B) Quartimax Rotated Factor Analyses:

Items	Factor 1	2	3	4	5
All	.3166	.6043	.0081	.6419	.3484
12.5-87.5	.6362	.3840	.6332	-.2582	.0424
25-75	.5039	-.0804	.5519	.5365	-.1253

C) Theoretical Scales: All Items

Restrictive Control	.6663	Humanistic	.5055
Protective Benevolence	.6731	Desirability	.3834

Guttman Split Half Estimates

Non-Rotated Factor Analyses:

Items	Factor 1	2	3	4	5
All	.5880	.4689	.5630	-.0955	.0205
12.5-87.5	.5448	.4258	.5862	.0828	-.2025
25-75	.4868	.4910	.3243	.2897	-.0852

B) Quartimax Rotated Factor Analysis

Items	Factor 1	2	3	4	5
All	.0796	.4002	.0962	.6311	.3043
12.5-87.5	.5693	.3407	.5783	-.2191	-.2025
25-75	.4481	-.3940	.5605	.5776	-.6885

C) Theoretical Scales: All Items

Restrictive Control	.6310	Humanistic	.4824
Protective Benevolence	.6341	Desirability	.4308

APPENDICES

FACTOR I SUMMARY

Rotation	N (-)	(½ / A)	DESC.	RCtr	Associations with Dimensions (+) PBen	Hum	Des	/ RCtr	(-) PBen	Hum	Des
All Items:											
NR	39(6)	(.5880/.6965)	RCtr	22	8	1	0	0	1	6	1
V	31(8)	(/)	RCtr	14	10	0	0	0	0	7	0
Q	31(11)	(.0796/.3166)	RCtr	15	5	0	0	1	2	8	0
12.5-87.5:											
NR	37(10)	(.5448/.5662)	RCtr	19	9	0	0	0	0	9	0
V	32(8)	(/)	RCtr	16	10	0	0	0	0	6	0
Q	33(7)	(.5693/.6362)	RCtr	17	10	0	0	0	0	6	0
25-75:											
NR	27(7)	(.4868/.5142)	RCtr	14	6	0	0	0	0	7	0
V	20(4)	(/)	RCtr	11	5	0	0	0	0	4	0
Q	20(4)	(.4881/.5039)	RCtr	12	4	0	0	0	0	4	0

NR = non rotated
V = varimax rotation
Q = quartimax rotation
RCtr = restrictive control
N = number of items in the factor
(-) = number of negatively correlated items
½ = Guttman split-half estimates
A = alpha estimates
Association = (+) = positive items positively correlated
= negative items negatively correlated
(-) = positive items negatively correlated
= negative items positively correlated

FACTOR II SUMMARY

Rotation	N (-)	(½ / A)	DESC.	Associations with Dimensions (+) RCtr	PBen	Hum	Des	(-) / RCtr	PBen	Hum	Des
All Items:											
NR	21(6)	(.4689/.3370)	PBen	8	5	1	1	0	1	5	0
V	23(7)	(/)	RC & CY	11	5	0	0	1	1	5	0
Q	30(7)	(.4002/.6043)	PBen	14	10	0	0	0	0	6	0
12.5-87.5:											
NR	15(4)	(.4258/.4064)	PP	4	0	1	0	1	1	1	7
V	15(5)	(/)	PC	3	1	0	0	0	0	1	10
Q	15(5)	(.3407/.3840)	PP	3	0	1	0	0	0	1	10
25-75:											
NR	11(0)	(.4910/.5655)	NHA	2	2	5	0	1	1	0	0
V	12(4)	(/)	PBen	5	3	0	0	0	0	3	1
Q	10(4)	(.3940/.0804)	PBen	4	2	0	0	0	0	3	1

PBen = protective benevolence
RC & CY = restrictive control and cynicism
PP = personal pathology
PC = Psychology cynicism
NHA = negative hospital attitude

FACTOR III SUMMARY

Rotation	N (-)	(½ / A)	DESC.	Associations with Dimensions (+) RCtr	PBen	Hum	Des	(-) RCtr	PBen	Hum	Des
All Items:											
NR	12(0)	(.5630/.5916)	Hum	1	3	6	0	1	0	0	1
V	17(5)	(/)	PP & PC	4	0	0	0	0	1	0	12
Q	7(2)	(.0962/.0081)	Hum	0	2	1	0	4	0	0	0
12.5-87.5:											
NR	13(0)	(.5862/.5783)	Hum	1	4	5	0	1	2	0	0
V	13(0)	(/)	NHA & ME	2	3	6	0	0	2	0	0
Q	15(0)	(.5783/.6332)	Hum	2	4	5	0	2	2	0	0
25.75:											
NR	7(4)	(.3243/.1858)	?	1	0	0	0	1	1	2	2
V	11(0)	(/)	HH &I	2	2	3	0	1	2	0	1
Q	11(0)	(.5605/.5519)	Hum	2	2	3	0	1	2	0	1

Hum = humanistic

PP & PC = personal pathology and Psychology cynicism

NHA & ME = negative hospital attitude and mythical etiology

? = ?

HH & I - humanistic hospital and idealism

FACTOR IV SUMMARY

Rotation	N (-)	(½ / A)	DESC.	Associations with Dimensions (+) RCtr	PBen	Hum	Des	(-) RCtr	PBen	Hum	Des
All Items:											
NR	4(2)	(.0955/.0418)	NPD	0	1	0	0	1	1	1	0
V	11(4)	(/)	H & S	0	2	3	0	6	0	0	0
Q	16(0)	(.6311/.6419)	Hum	2	3	7	0	3	1	0	0
12.5-87.5:											
NR	7(4)	(.0828/.0659)	I & PD	0	3	1	1	2	0	0	0
V	11(7)	(/)	NPD	3	2	0	1	2	1	2	0
Q	10(5)	(.2191/.2582)	NPD	2	2	1	1	2	0	2	0
25-75:											
NR	5(4)	(.2897/.3425)	Des	3	0	0	0	0	1	1	0
V	7(0)	(/)	NHA	1	1	2	0	2	0	1	0
Q	7(0)	(.5776/.5365)	Hum	1	1	2	0	2	0	1	0

NPD = negative psychiatric desirability
H & S = humanistic and sympathy
Hum = humanistic
I & PD = idealism and psychiatric desirability
Des = desirability
NHA = negative hospital attitude

FACTOR V SUMMARY

Rotation	N (-)	(½ / A)	DESC.	Associations with Dimensions (+) RCtr	PBen	Hum	Des	(-) RCtr	PBen	Hum	Des
All Items:											
NE	9(6)	(.0205/.1850)	Des	0	1	0	6	1	0	1	0
V	15(0)	(/)	NE	2	3	6	0	3	1	0	0
Q	16(0)	(.3043/.3484)	Des	2	3	7	0	3	1	0	0
12.5-87.5:											
NR	7(3)	(-.2025/.0424)	PD	0	0	0	2	2	1	2	0
V	9(3)	(/)	PBen	2	0	0	2	2	1	2	0
Q	7(3)	(-.2025/.0424)	PD	0	0	0	2	2	1	2	0
25-75:											
NR	4(2)	(-.0852/-.1194)	PD	0	0	0	2	2	0	0	0
V	7(3)	(/)	Des	0	0	0	3	1	0	3	0
Q	7(3)	(-.6885/-.1253)	Des	0	0	0	3	1	0	3	0

Des = desirability
NE = necessary evils (psychiatric hospitalization etc.)
PD = psychiatric desirability
PBen = protective benevolence

FINAL AGGREGATE OF ITEMS

FACTOR 1 : 26, 44, 49, 51, 52, 59, 80, 81, 89, 92, 97, 105, 117, 138, 140.

FACTOR 2 : 15, 36, 94, 106, 120, 121, 123, 127, 143.

FACTOR 3 : 8, 19, 60, 61, 75, 86, 114, 115, 124.

FACTOR 4 : 2, 3, 5, 79, 135, 137, 149.

CONSENT FORM

PSYCHIATRIC BELIEFS BATTERY

This study involves the development of a questionnaire evaluating peoples beliefs regarding psychiatric illness, it's sufferers, psychiatric hospitals, hospital staff, and methods of treatment. It involves completing a single questionnaire and requires approximately 45 minutes. However, it may be completed at your own pace, at your leisure. Your results will be kept strictly confidential, and will be used solely for the statistical development of this questionnaire. You are not obligated in any way to participate in this study and may withdraw at any time.

The results of this study, and your own individual results, will be made available to you on request. If you would like to participate in this study please complete and sign the informed consent below.

I have read and understand the above statements and the procedures to be used in this study and I agree to participate in this study. I understand that I may withdraw from this study at any time without any consequences.

Print Name_____

Date_____

Participants Signature_____

PSYCHIATRIC BELIEFS BATTERY

1) Psychiatric patients need to be cared for.
T F

2) Unfortunately, many psychiatric hospitals are more like prisons than places of care for the ill.
T F

3) Psychiatric hospitals rely too heavily on the use of punishment.
T F

4) Psychiatric illness is simply an escape from the difficulties of daily living.
T F

5) Psychiatric hospitals should have more psychiatrists on staff rather than so many different professionals and services.
T F

6) Psychiatric patients should be eligible for workman's compensation for their illness.
T F

7) There is little treatment that a psychiatric hospital can really offer except to provide a warm, peaceful place for patients to rest.
T F

8) Psychiatric hospitals should have as few restrictions as possible.
T F

9) It is easy to recognize psychiatric patients.
T F

10) Psychiatric patients should be paid for any work that they do while in the hospital.
T F

11) Psychiatric hospital staff need to be allowed to use firm discipline with the patients.
T F

12) Some forms of psychiatric illness are caused by disorders of the nervous system.
T F

13) Psychiatric illness can be prevented.
T F

14) I am quite able to make correct decisions on difficult questions.
T F

15) A psychiatric illness does not stop someone from functioning in the community.
T F

16) It is necessary to restrict some of the rights of psychiatric patients.
T F

17) Given too much freedom, psychiatric patients will only hurt themselves.
T F

18) In an effort to ease his childhood pain, the psychiatric patient must be shown all the tenderness possible.
T F

19) People with too many 'bad thoughts' are likely to develop a

psychiatric illness.

T F

20) The treatment of a psychiatric patient should continue after his release from hospital.

T F

21) When psychiatric patients are released from hospital, they can be expected to continue life normally.

T F

22) One must be careful that psychiatric hospitals don't contain items that could be used as a weapon against others.

T F

23) It would be foolish to think that anyone could have a normal relationship with a psychiatric patient.

T F

24) If you give psychiatric patients too much to do, it only wears them out.

T F

25) Only the socially unfit develop psychiatric illnesses.

T F

26) Some psychiatric patients should be sterilized to keep them from having children.

T F

27) Psychiatric hospitals have to be kept undecorated like prisons since the patients break everything anyways.

T F

28) I am never able to do things as well as I should.

T F

29) People who are happy and successful at work won't likely develop a psychiatric illness.

T F

30) All that a psychiatrist can do is ensure that a patient is adequately sedated.

T F

31) Hospital staff should remember that psychiatric patients can't always help behaving in unusual ways.

T F

32) Most psychiatric patients don't want to get better.

T F

33) Too much money is spent on treatment services for psychiatric patients.

T F

34) My life is full of interesting activities.

T F

35) It is more important to respect a person's right of freedom, than to commit them to a psychiatric hospital.

T F

36) Psychiatric illness is a weakness.

T F

37) Too much time and money is wasted on recreational activities for psychiatric patients.

T F

38) Money spent on improving psychiatric treatment is wasted.

T F

39) A firm approach is needed in treating psychiatric patients.

T F

40) All that one can really offer the psychiatric patient are the necessary sedatives, and a little counseling.

T F

41) It is useless to try and talk normally to psychiatric patients.

T F

42) Government health dollars are better spent on general hospitals than psychiatric hospitals.

T F

43) If you are too easy on psychiatric patients, they'll just try and take advantage of you.

T F

44) Psychiatric hospital staff should be able to use restraint more often with difficult patients.

T F

45) I believe people tell lies any time it is to their advantage.

T F

46) The staff of psychiatric hospitals can at least pretend to be friends with patients.

T F

47) Psychiatric hospitals are necessary to isolate the patients from the public.

T F

48) Psychiatric patients should be restrained as a last resort.

T F

49) Patients in a psychiatric hospital should do as they are told.

T F

50) Psychiatric hospitals should have familiar and comfortable surroundings rather than locked doors and windows.

T F

51) Locking psychiatric patients on a single ward helps to keep them from becoming lost and confused.

T F

52) Male and female psychiatric patients should be kept apart.

T F

53) Psychiatric patients who are parents should be closely supervised.

T F

54) Many forms of psychiatric illness can go unnoticed.

T F

55) Working with psychiatric patients can be very rewarding.

T F

56) There is a growing need for more psychiatric hospitals.

T F

57) While a normal person couldn't stand being locked up in a psychiatric hospital, patients don't even notice.

T F

58) Psychiatric patients should not be labelled or discriminated against because of their problems.

T F

59) Psychiatric patients should have the same rights as others.

T F

60) If psychiatric hospitals had enough well trained staff, many of the patients would get well enough to live outside of the hospital.

T F

61) Psychiatric hospitals necessarily keep patients from doing many things they might enjoy.

T F

62) Psychiatric hospitals should make patients feel 'at home'.

T F

63) The children of parents with psychiatric illnesses are likely to develop the same problems as their parents.

T F

64) Psychiatric disorders are not illnesses of the lower classes.

T F

65) The rights of psychiatric patients are restricted for their own good.

T F

66) The community shouldn't have to support psychiatric patients.

T F

67) Psychiatric patients should not be kept in hospitals against their will.

T F

68) Too much money is spent keeping psychiatric hospitals looking good for their patients.

T F

69) Some psychiatric patients should not be allowed to marry.

T F

70) Hospital staff must ensure that psychiatric patients don't harm one another.

T F

71) If a patient doesn't like the form of treatment which he is receiving, he should be allowed to change it.

T F

72) If someone gave me too much change, I would tell him.

T F

73) Psychiatric hospitals give patients a chance to get away from everyday responsibilities, so that they can concentrate on getting well.

T F

74) Hospital staff must at least seem friendly to psychiatric patients.

T F

75) Psychiatric patients should have a wide range of priveleges.

T F

76) Many psychiatric patients make strong, wholesome friendships while in the hospital.

T F

77) I would be willing to do something a little unfair to get something that was important to me.

T F

78) One has to feel sorry for psychiatric patients.

T F

79) Drugs should be used sparingly and only on a short term basis with psychiatric patients.

T F

80) Psychiatric patients should be able to refuse treatment even if it might help them.

T F

81) Locked wards are for the patients' own good.

T F

82) I did many very bad things as a child.

T F

83) Psychiatric hospitals should be surrounded by a high barbed wire fence.

T F

84) Allowing psychiatric patients to keep any personal belongings in hospital will only lead to trouble.

T F

85) Psychiatric patients should be treated with respect.

T F

86) Many psychiatric patients come from uncaring homes.

T F

87) One should approach psychiatric patients with kindness, but never entirely let your guard down.

T F

88) Psychiatric patients should be clearly informed of their rights and freedoms in hospital.

T F

89) Psychiatric patients should be allowed to vote.

T F

90) It is important to keep the psychiatric patient calm and contented,even if it means lying to them.

T F

91) It remains beyond the scope of modern psychiatry to prevent psychiatric illness.

T F

92) If psychiatric patients arn't carefully watched, they are bound to get into trouble.

T F

93) It's not always easy to spot someone with a psychiatric illness.

T F

94) A restrictive hospital is the best place for anyone with a psychiatric illness.

T F

95) It's unrealistic to expect hospital staff to always be friendly and caring with psychiatric patients.

T F

96) I get along with people at parties quite well.

T F

97) Doorways in psychiatric hospitals should be kept securely locked.

T F

98) Getting psychiatric patients to talk about their problems is a waste of time.

T F

99) Although necessary, it's unfortunate that people have to spend time in psychiatric hospitals.

T F

100) Psychiatric illness is a punishment for being a bad person.

T F

101) Psychiatric patients should always be provided distractions to keep them from thinking about their problems.

T F

102) Once someone has a psychiatric illness, they are never the same again.

T F

103) My daily life includes many activities I dislike.

T F

104) If people were taught how to deal with stress, there would be less psychiatric illness.

T F

105) Psychiatric patients present little risk of harm to others.

T F

106) A psychiatric hospital is the best place for someone with a psychiatric illness.

T F

107) The ability to listen and understand is the single most important quality of a paychiatric hospital's staff.

T F

108) Psychiatric treatment is as good today as it will ever be.

T F

109) Providing a structured setting for psychiatric patients helps them to learn how to organize their lives.

T F

110) Psychiatric illness is largely a lack of willpower.

T F

111) Psychiatric patients should have a say in how they are treated in hospital.

T F

112) Psychiatric illnesses are complex and usually involve emotional, social and physical causes.

T F

113) I am one of the lucky people who could talk with my parents about my problems.

T F

114) A lot of psychiatric illness could have been avoided if more parents loved their children.

T F

115) Psychiatric patients should have access to lawyers to help them get out of the hospital.

T F

116) Many psychiatric patients are quite capable of returning to positions of responsibility.

T F

117) The children of psychiatric patients should be protected from their parents.

T F

118) Even though a psychiatric patient appears to be alright, he is never really cured.

T F

119) Psychiatric illness often develops in people that worry too much about their problems.

T F

120) Psychiatric patients can't be expected to be any more responsible for their actions than a child.

T F

121) Nervous breakdowns are not a sign of weakness.

T F

122) If psychiatric hospitals were too comfortable, more people would

want to stay there.

T F

123) Psychiatric treatment should be more directed towards preventing illness.

T F

124) Often psychiatric illnesses develop if people work too hard.

T F

125) I am glad I grew up the way I did.

T F

126) It's important for the staffs' own sake that they don't become too friendly with hospital patients.

T F

127) Psychiatric hospitals are only necessary for a small pecentage of people with psychiatric illnesses.

T F

128) Psychiatric patients returning to the hospital from an outing should always be searched for knives and matches.

T F

129) Counsellors cannot be expected to be very successful rehabilitating psychiatric patients.

T F

130) Psychiatric staff probably do not have the time to treat all patients as individuals.

T F

131) Many things make me feel uneasy.

T F

132) Psychiatric illnesses are completely different from all other illnesses.

T F

133) Psychiatric patients only really need a place to rest.

T F

134) The only thing that can be done for psychiatric patients is to give them drugs to keep them quiet.

T F

135) Psychiatric hospitals are too institutionalized.

T F

136) The briefer patients stay in a psychiatric hospital, the better.

T F

137) Psychiatric hospitals are frightening places.

T F

138) Psychiatric patients should not be trusted as babysitters.

T F

139) Psychiatric hospitals don't provide a realistic preparation for the patients return to the community.

T F

140) Psychiatric nurses must act as police and keep patients under control.

T F

141) Some psychiatric illnesses are only temporarily disruptive.

T F

142) I often question whether life is worthwhile.

T F

143) Psychiatric illnesses should not be treated in general hospitals.

T F

144) Treatment of psychiatric illness should concentrate on returning the patient to the community.

T F

145) I am always prepared to do what is expected of me.

T F

146) Psychiatric hospitals are not frightening to patients.

T F

147) I am careful to plan for my distant goals.

T F

148) Psychiatric hospitals are more helpful if they provide comfortable and sympathetic surroundings.

T F

149) Hospital staff should try and make friends with their patients.

T F

150) If they try hard enough, psychiatric staff can find simple answers to patient problems.

T F

151) Psychiatric patients are a danger to each other and should always be closely watched.

T F

152) Programs for preventing psychiatric illness are too costly and misguided.

T F

153) When treating psychiatric patients, one should be caring and sympathetic.

T F

154) I find it very difficult to concentrate.

T F

155) Most psychiatric patients don't care how they look.

T F

156) The benefits of shock therapy far outway the dangers.

T F