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Some Factors Affecting College Students' Willingness to Interact with Hospitalized Mental Patients

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SOME FACTORS AFFECTING COLLEGE STUDENTS'

WILLINGNESS TO INTERACT WITH

HOSPITALIZED MENTAL PATIENTS

BY

JOAN E. WILKINS

A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE

REQUIREMENTS FOR THE DEGREE OF

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IN

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ABSTRACT

Since the Mental Health Service Acts of 1963 and 1965, increasing numbers of psychiatric patients have been discharged back into communities for continuing treatment. Many communities have reacted negatively to this influx of ex-patients. Since the nature of the public's reaction affects the establishment of community facilities as well as the course of ex-patients' stays in the community, it is important for mental health professionals to better understand public reaction to mental patients.

Since multiple factors influence behavior, the primary purpose of the present investigation was to simultaneously investigate, through the use of a multivariate design, a variety of subject, situational and patient variables that affect people's reactions toward mental patients. A second purpose was to develop an instrument to measure people's behavior toward mental patients. A Behavioral-Intentions measure was developed to assess people's willingness to interact with hospitalized mental patients. In order to determine the usefulness of the Behavioral-Intention measure as a substitute for subjects' actual behavior, subjects' overt behavior was also recorded and the degree of the relationship between subjects' Behavioral-Intention scores and their overt behavior was assessed.

Subjects were 45 male and 45 female undergraduate students (Total = 90). Subjects' attitudes toward mental patients were assessed

using the semantic differential. The Behavioral-Intention measure consisted of eight hypothetical situations in which subjects rated their willingness to interact with hospitalized mental patients on a six-point scale. Subjects were contacted by the experimenter two weeks after completing the Behavioral-Intention measure and asked to engage in one of the activities described on the Behavioral-Intention measure. Subjects' responses were recorded on the Overt Behavior measure.

The factors of subject sex and attitude toward mental patients, patient socio-economic status and the social intimacy and potential disclosure of the encounter were analyzed using a $3 \times 2 \times 2 \times 2 \times 2$ analysis of variance. The Behavioral-Intention measure was employed as the dependent measure. The relationship between the Behavioral-Intention (BI) and Overt Behavior (OB) measure was assessed using Gamma, which indicates the probability of like ordering.

People were significantly more willing to meet with a patient in situations of low intimacy as compared to situations of high intimacy. People with positive attitudes were significantly more willing to meet with patients as compared to people with neutral or negative attitudes regardless of whether the meeting was to remain confidential or be publicized. When the meeting was to be publicized, only people with negative attitudes indicated significantly less willingness to meet with a patient as compared to when it would remain private.

Women indicated significantly less willingness to engage in an activity with patients when the activity would be publicized as compared to when it would remain confidential. Men however, showed no difference in their willingness to interact with patients depending on the

potential disclosure of the meeting. No main effect sex difference was found. Finally, the socio-economic status of the patient did not influence people's willingness to interact with a patient.

In addition, men and women with neutral attitudes responded differently when contacted by the experimenter and asked to come in to meet a patient. Women, once contacted, were more likely to attend the meeting, whereas men were more likely to refuse to attend. The Gamma co-efficient of .411 was found for the relationship between the BI and OB measures. Although considerable variance is still unaccounted for by this relationship, this magnitude of association is noteworthy given the complexities of the social situation; it compares favorably with other BI-OB relationships reported in the literature and it indicates that the BI measure was a reasonable dependent measure for this study.

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TABLE OF CONTENTS

	Page
ACKNOWLEDGEMENT.	v
LIST OF TABLES AND FIGURES	viii
INTRODUCTION	1
Statement of the Problem.	1
Variables that Affect Behavior.	9
Behavioral Assessment	20
METHOD	30
Subjects.	30
Instruments	31
Procedure	36
RESULTS.	41
Relationship of Behavioral-Intention Measure and Overt Behavior Measure.	49
Relation of Overt Behavior and Sex of Subject	51
Sample Characteristics.	53
Post-Experimental Questionnaire	55
DISCUSSION	61
Behavioral-Intention Measure.	62
Factors Influencing Behavioral-Intentions	63
The BI-OB Relationship--Comparison to Previous Research	69
Generalizability of Results	75
Implications for Community Psychology	77
Implications for Future Research.	80
REFERENCES	83
APPENDIX A: Questionnaire Including the Semantic Differential and Behavioral-Intention Measures.	90
APPENDIX B: Volunteer Information	107
APPENDIX C: Post-Experimental Questionnaire	109

TABLE OF CONTENTS (Continued)

	Page
APPENDIX D: Summary Table of Newman-Keuls Tests.	112
APPENDIX E: Contingency Table: Subjects Familiar or Not Familiar with Psychiatric Hospitals Who Attended or Did Not Attend Activity.	114

LIST OF TABLES AND FIGURES

Table		Page
1.	Factors Influencing Behavioral-Intentions.	42
2.	Summary Table of Analysis of Variance: Factors Influencing Behavioral-Intentions.	43
3.	Disclosure by Attitude Interaction: Means	45
4.	Disclosure by Sex Interaction: Means.	50
5.	Summary Table of Relationships Between Measures and Associated Tests of Significance	52
6.	Contingency Tables of Male and Female Subjects Who Attended or Did Not Attend Activity.	54
7.	Summary Table of Analysis of Variance: Class in Which Questionnaire was Completed.	56
8.	Summary Table of Analysis of Variance: Reported Major . .	57
Figure		
1.	Disclosure by Attitude Interaction: Disclosure at Each Level of Attitude.	46
2.	Disclosure by Attitude Interaction: Attitude at Each Level of Disclosure.	47

INTRODUCTION

Statement of the Problem

In 1960, the report of the Joint Commission on Mental Health asserted that it was no longer acceptable to continue the heavy reliance on public psychiatric hospitals for the delivery of services to the mentally ill. The recommendations of this report, plus others, were translated into the Community Mental Health Service Acts of 1963 and 1965 which were designed to transfer the delivery of services from psychiatric hospitals to community based treatment facilities. Thus the new emphasis has been on reducing the census of psychiatric hospitals, reducing the length of hospitalization and maintaining previously hospitalized patients in the community. From 1955 to 1970 the number of persons in public mental hospitals has decreased by 39% (Kanno, 1971). About 2.5 million people each year, however, are hospitalized for what has been labeled "mental illness" (NIMH, 1970). Patients are being hospitalized for shorter durations and are being discharged back into the communities for continuing treatment. Problems concerning patients' maintenance and re-integration into the community have emerged. Many communities have reacted negatively to the influx of mental patients and to the development of half-way houses and other partial hospitalization services.

The New York Times Magazine (May 21, 1978) summarized some of the opposition that had developed in the New York area. In 1971 residents of

Flatbush organized to fight plans to establish a half-way house for discharged patients. After 18 days of organized protests, the New York State Department of Mental Hygiene abandoned the project. One protester commented, "I don't know much about mental health, but suppose one of our children teased a patient, and he went berserk." Similar reactions developed in Suffolk County on Long Island during 1972, in Long Beach, Long Island during 1973 and on the West Side of New York during 1974.

Abstract expressions of support for the policy of de-institutionalization rapidly evaporate when citizens become aware of plans to establish half-way houses or family-type residences in their midst: formidable opposition coalesces overnight when a specific site is suggested. Fears of violence or sexual assault are invariably expressed, along with anxiety about bizarre behavior in the neighborhood, a lowering of property values, noisy disruptions, destruction of property, panhandling, prostitution, etc. (p. 15)

The nature of public reaction affects the establishment of community treatment facilities, as well as the course of an individual patient's stay in the community. It is clearly important for mental health professionals and community planners to better understand public reaction to mental patients. Most reports of public reaction, however, have been documented by the popular media and have been predominately anecdotal in nature. Until very recently, professional studies have focused on public attitudes toward the mentally ill instead of people's actual behavior when interacting with the mentally ill.

The public's general attitudes toward mental patients have been extensively investigated since the 1950's. This body of literature can be divided into two groups with opposing conclusions. The first, more optimistic group supports the conclusion that public knowledge about mental illness has grown since the 1950's and that the public no longer

stigmatizes or rejects the mentally ill (Crocetti & Lemkau, 1963; Lemkau & Crocetti, 1962; Rootman & LaFave, 1966). The second, more pessimistic group supports the conclusion that although the public may have more knowledge and may accept the medical model of mental illness, there has been little or no improvement in the public's basic negative attitudes and patterns of rejection (Bord, 1971; Lamy, 1966; Nunnally, 1961; Phillips, 1963, 1966, 1967; Tringo, 1970).

Rabkin (1974, 1975) has provided a thorough and detailed review of this literature and has summarized several major conclusions. First, the evidence does seem to indicate that people are better informed about mental illness, and either believe, or know that it is correct to say, that "mental illness is an illness like any other." However, the common image of the mental patient continues to be negatively toned and ex-mental patients are simply not perceived with the same trust, good will, and restoration of the former "normal" status that is assigned to ex-medical patients.

Along with being held in low esteem, certain laboratory studies (Farina & Ring, 1965; Farina, Holland & Ring, 1966; Ring & Farina, 1969) have indicated that an individual who is known to have a history of psychiatric hospitalization, as a result, is perceived as being more inadequate and incompetent in his behavior than a control person. For example, Farina and Ring (1965) had unacquainted undergraduates work together on a simple motor task which required cooperation. They informed one member of some pairs that their partner had been in a mental hospital. When co-workers were believed to be mentally ill, subjects preferred to work alone and blamed the other for inadequacies of performance, in spite of the fact that there was no behavior to justify this

perception. These investigators concluded that believing a person to be mentally ill strongly influenced the perception of that individual and distorted it in the direction of the pejorative stereotype.

Another consequence of being classed as a psychiatric patient is that it seems to increase the problems in securing employment. Landy and Griffith (1958) and Whatley (1959) reported that employers were reluctant to hire ex-mental patients, and that some were forced to accept wages below the standard rate for jobs they were given. Olshansky, Grob and Malamud (1958) interviewed 200 employers whose workers constituted 14% of the total labor force in the greater Boston area. One-quarter of the employers said they would not hire an ex-mental patient. Of those employers who said they would consider hiring an ex-mental patient, 40% reported that they would consider such a person only for certain jobs which were predominately undesirable, unskilled jobs. Only 13% of the entire group had knowingly hired an ex-patient in the preceding three years. More recently, Farina and Felner (1973) found that a history of psychiatric hospitalization led to a trend for fewer jobs to be offered, less friendly behavior on the part of employers and a lowered estimate of the probability of finding a job.

Farina, Felner and Boudreau (1973) investigated the response of workers to former mental patients. They told employers that the management was trying a new system for predicting how well an applicant would do if hired. They asked workers to interview an applicant who was described as normal or as having been mentally ill. For male workers interviewing a male applicant, the authors found that a history of mental illness produced highly negative reactions, led to judgments of the applicant as less likely to get along with other workers, as having many

liabilities and to the recommendation that he not be hired. This study substantiates the research showing that ex-patients are viewed as poor job prospects and are less likely to be hired. It also indicates that if the psychiatric history of ex-patients is known when they do find a job, they are likely to experience difficulties with co-workers.

This discrimination is a serious consequence for having undergone psychiatric treatment. A person's self-esteem and social status in our society is greatly determined by the nature of one's employment. If a patient cannot find a job or if the job is an undesirable one, the individual's standing in the community will likely be marginal which will, in turn, make re-adjustment more difficult.

The attitude and behavior of the returning patient's family also significantly affects his adjustment in the community. Freeman and Simmons (1958) found that psychiatric and other medical factors were less important in determining patients' levels of performance and length of stay out of the hospital than were the expectations of the relatives to whom the patients returned. Patients with low levels of performance were most tolerated in parental families where the patients occupied the role of child. High performance patients clustered in conjugal families or in non-familial residences. Liberman, Leff and Vaugh (1976) found that family members who were overly critical and overly involved in helping discharged patients played a major role in their return to the hospital. Paul (1969) reviewed the literature concerning the status of discharged, chronic mental patients and concluded: "Thus, the patients' behavior, the degree of distress imposed, and tolerance and support of significant others may all be viewed as important to (the patients') community tenure" (p. 83).

Thus, mental patients returning to the community are faced with generally negative attitudes and stereotypes as well as actual job discrimination and community rejection. This societal reaction as well as the attitudes and expectations of relatives will greatly affect a patient's re-adjustment and his course of stay in the community.

Societal reaction to mental patients, however, is not consistently negative. Farina, Thaw, Lovern and Mangone (1974) asked a non-representative sample of residents to respond to a tape of a conversation with a patient who was described as a surgical patient or a mental patient. Although residents predicted the mentally ill patient to have more difficulty finding a job and preferred the surgical patient as a co-worker on a job, they reported that they would be more likely to invite the mentally ill patient to a neighborhood party. In addition, when interviewing employees, Farina, Felner and Boudreau (1973) found some workers (predominately females) who indicated that they expected to get along better with ex-mental patients than with ordinary job applicants. Farina and Felner (1973) also reported anecdotal data that a job applicant representing himself as an ex-mental patient was offered a job by one employer who then proceeded to counsel the applicant not to tell other employees of his psychiatric history.

Thus, along with the negative societal attitudes and rejecting behavior there is also evidence of a more positive orientation. In interviewing ex-mental patients, Grove and Fain (1973) reported their impressions that "a substantial minority of ex-patients were initially somewhat embarrassed and uncomfortable about having been in a mental hospital, but that they did not perceive the stigma of hospitalization as having had any serious or long-run consequences" (p. 500). Farina

et al. (1974) concluded that the public will be in conflict when dealing with the mentally ill. The public will not behave in a uniformly bad way, perhaps because there are social values encouraging kindness and help in relation to those in difficulty. Some reactions will be negative, but many may be more positive than toward a normal person.

Given that public behavior is not uniformly negative, it is very important to understand what factors influence the public's acceptance or rejection of people who have been hospitalized in psychiatric institutions. There are two methodological problems in this area which have impeded the clarification of this issue.

First, the literature to date has not adequately studied the public's actual behavior in relation to the mentally ill. The predominant focus has been on the public's attitudes. Lack of information about the public's actual behavior toward mental patients is due both to the difficulty of establishing good behavioral measures and also to obvious ethical prohibitions against placing mental patients in situations in which they may experience rejection and discrimination. However, the necessity of assessing behavior remains strong. Wicker (1969) reviewed the literature on attitude-behavior relationships and found that measured attitudes were often unrelated or only slightly related to overt behavior and rarely were attitude-behavior correlation coefficients larger than .30. In other words, very infrequently did attitudes account for more than 10% of the variance in the overt behavior measure. It is clearly untenable to assume that people's attitudes, as they are typically measured, strongly reflect or accurately predict their actual behavior.

Second, and more importantly, it is recognized that multiple

factors influence behavior (Ehrlich, 1969; Sample & Warland, 1973; Shofield, 1975; Weinstein, 1972). Wicker (1969) argued that attitudes should be viewed as only one of many potential influences on people's behavior. The inconsistent findings and controversy in this area are due in part to the fact that many potentially important variables have not been controlled or systematically investigated. Not all ex-mental patients are badly treated by everyone in every situation. The focus, therefore, needs to shift to the pattern of interactions between relevant factors. Lamy (1966) has asked: "What are the salient aspects that may be inferred to underlie the judgmental pattern used in regard to persons who have had mental illness" (p. 451).

A more accurate representation of the problem would therefore take the form: What types of patients in interaction with what types of people in what situations will result in what degree of acceptance or rejection. Rabkin (1975) criticized researchers in this area for excluding from consideration potentially relevant personal and situational influences. She concluded that systematic analysis of these variables would contribute substantially to our understanding of people's behavior toward mental patients.

The present study was designed to investigate the relative influence of several factors on people's willingness to interact with hospitalized mental patients while attempting to minimize the two methodological problems previously discussed. The purpose of the present investigation was therefore two-fold. The first purpose was to investigate simultaneously a variety of subject, situational and patient variables that affect people's behavior toward mental patients through the use of a multi-variate design. This design permits significant

interactions among factors to be detected and interpreted. The second purpose was to develop a practical and effective instrument to measure people's behavior toward hospitalized mental patients.

Variables that Affect Behavior

The potentially relevant variables that affect behavior can be grouped into three categories: (a) Subject characteristics, (b) Situational variables, and (c) Object characteristics (characteristics of mental patients).

Subject Characteristics

Numerous subject characteristics have been suggested as possible influences on behavior. These include attitudes toward mental patients, competing attitudes and motives, sex, age, education and socio-economic status (SES), and normative beliefs (what subjects think they should do). Much work is needed in this area to operationalize and test the influence of each variable. The literature concerning subjects' attitudes, sex, age and education and SES will be reviewed. Most studies that have investigated these variables have looked at the relationship between those factors and subjects' expressed attitudes and opinions about mental illness and mental patients.

Attitudes. The public's attitudes toward the mentally ill have been summarized earlier. The majority of investigators in this area agree that the public continues to hold a pejorative stereotype of mental illness and views the mentally ill as unpredictable, untrustworthy and undesirable. As mentioned previously, people's attitudes toward mental patients have been assumed to influence their behavior. Although it is

now apparent that many other factors influence behavior as well, people's general attitude is still an important variable which is necessary for comparison with earlier research.

Sex. Early research on people's attitudes indicated no differences with relation to subjects' sex. Whatley (1959) sampled 2000 adults using social distance scales; Nunnally (1969) used the semantic differential to assess the attitudes of 250 adults; and Lamy (1966) assessed 158 subjects' views of ex-convicts and ex-mental patients. All three authors reported no sex differences.

However, more recent investigations have found sex differences in people's attitudes and behavior toward the mentally ill. Tringo (1970) investigated the hierarchy of preference people held among various categories of disabled and stigmatized people. He reported that subjects' sex did not affect the relative ranked position of the disability groups in the hierarchy (the mentally ill were ranked the lowest by both males and females). However, the author did find that female subjects expressed a preference for relatively less social distance toward all the disability groups as compared to male subjects.

In a series of three experiments, Farina, Felner and Boudreau (1973) asked employees to interview confederate job applicants who were described as ex-mental patients or normals and who acted either tense or calm. In the first experiment, female employees interviewed female applicants in a department store. When nervous, the applicant was strongly and decisively rejected; but whether the applicant had a psychiatric history or not made no difference. In the second experiment, male employees of a V.A. hospital interviewed male confederate applicants. Nervous behavior again led to rejection but a history of mental

illness also caused strong rejection. To control for setting effects, a third experiment was performed. Female employees of the same V.A. hospital interviewed female applicants. The results were the same as those of the first experiment: a history of hospitalization did not lead to rejection but nervous behavior did. The authors suggest that females are more tolerant and less rejecting of the mentally ill than males.

However, it should be noted that in each study males interviewed males and females interviewed females. It is possible that the sex of the patient is the important factor. To investigate this possibility, Farina and Hagelauer (1975) had female employees in a department store interview male applicants using the same design. Once again, for female subjects, the presence of tension led to rejection while a history of psychiatric hospitalization produced no differential effect. Unfortunately, the authors did not ask male employees to interview female applicants. However, the authors concluded that "It seems women accord full and unreserved acceptance to ex-mental patients in sharp contrast to men, who strongly rejected them" (p. 122). This tendency is also reflected in the finding that females are more empathetic than males (Hoffman, 1977). Thus, although there are inconsistent findings, the recent literature does suggest that females are more accepting than males. Especially since sex differences have been reported in many other areas (Maccoby & Jacklin, 1974), the sex of subjects is an important variable to include in any investigation.

Age. Subjects' age also appears to be associated with attitudes toward the mentally ill. Whatley (1959) gave social distance scales to a stratified sample of 2000 adults. He divided his sample into three

age groups (15-35, 36-55, 55 and up) and found a significant difference among all three groups. Younger subjects indicated less rejection and a preference for less social distance.

Woodward (1951) interviewed almost 4000 adults. He reported that the age breakdown on nearly all of the questions showed a clear-cut differential between subjects' ages, with the younger subjects showing uniformly more "humanitarian" opinions. Unfortunately, the data is reported only in terms of frequencies for each question. It was therefore impossible to assess the significance of the differences or the degree of the correlation.

Freeman (1961) interviewed relatives of former mental patients and found that age was negatively correlated with "enlightened" attitudes on three scales. Although the correlations were significant ($p < .01$), they were uniformly low ($r = -.21$, $r = -.13$, and $r = .18$).

Bowen, Twemlow and Boquet (1978) found differences in views about the etiology of mental illness to be associated with age. The older subjects believed mental illness to be biologically based, while the younger subjects saw the lack of proper nurturance during childhood as the cause. Unfortunately, once again only percentages were reported.

Nunnally (1961) also investigated the influence of subjects' age on attitudes toward and knowledge about mental illness. He cautioned that it is important to distinguish between people's attitudes and their theoretical knowledge or beliefs. Although he found important differences in the kinds of information held by young and old subjects, he found that the differences in attitudes were relatively small.

Thus, although the analyses of many studies is insufficient and although there is some confusion between attitudes and knowledge, age does seem to be negatively associated with positive attitudes. This relationship, however, appears to be relatively weak.

Educational level and socio-economic status (SES). Subjects' educational level and SES will be reviewed together since education is included as a component of SES by some authors. Many of the studies mentioned in the previous section also investigated the relationship between subjects' education or SES and their attitudes. Whatley (1959) found that low educational levels were associated with rejection and avoidance. Low income and low status occupations were also associated with rejection scores, although they accounted for smaller amounts of the variation.

Freeman (1961) also found that higher educational levels were correlated with "enlightened" attitudes on three attitude scales. As with age, the correlations, although significant, were quite low ($\underline{r} = .20$, $\underline{r} = .17$, $\underline{r} = .10$). Other variables often associated with SES (occupation, source of income, type of dwelling and area of residence) showed no significant relationship, although the correlations were in the expected direction. Nunnally (1961) also reported a small, but statistically significant, tendency for more educated subjects to hold less derogatory attitudes.

Freeman and Kassenbaum (1960) administered a 16-item questionnaire to 438 adults. Only six of the sixteen items correlated with education at the .01 probability level. These authors concluded that opinions about mental illness were only slightly, if at all, related to the level of formal education. Although not conclusive, these studies

suggest that subjects' higher education levels and perhaps higher SES are associated with positive attitudes. This relationship, like that between subjects' age and attitudes, appears weak.

Since all the potentially important variables cannot be included in any one study, only subjects' attitudes toward the mentally ill and subjects' sex were included as factors in the present investigation. Subjects' attitude was included since it has been assumed to influence people's behavior. Its inclusion also allowed for comparisons to previous studies to be made. Subjects' sex was included since sex differences have been found in a wide variety of investigations (Maccoby & Jacklin, 1974) as well as in the recent studies in this area.

Situational Variables

Although numerous authors have emphasized the need to investigate situational variables as they interact with other personal variables (Frideras, Warner & Albrecht, 1971; Rabkin, 1975; Wicker, 1969), there have been few investigations into the influence of situational variables on people's behavior toward mental patients. These investigations typically study the influence of the institution or setting on the behavior and attitudes of mental health professionals (Cohen & Struening, 1962; Gilbert & Levinson, 1957). However, there are no studies concerning the general public's behavior toward ex-mental patients under various situational conditions.

In other areas, the most common factors that have been investigated or assumed important are social distance (degree of the social intimacy of the interaction), disclosure (whether the interaction will

remain private or be publicized), actual presence of others, alternative behaviors available and unforeseen extraneous events.

Several studies investigating racial attitudes have suggested that both the level of social distance and the level of disclosure affect people's behavior. Linn (1965) examined the relationship between racial attitudes and overt behavior by asking subjects to pose for a photograph with a black person of the opposite sex. Four weeks before the picture-taking session, the author had asked subjects whether or not they would allow an interracial photo to be taken if it were to be used for a variety of purposes (disclosure). At the same time, subjects were asked whether or not they would interact with a black person in a variety of situations (levels of social distance). Unfortunately, the author called these measures attitude scales and combined the two scores. In addition, the results were reported in terms of percentage of subjects showing attitude-behavior discrepancies. Therefore, although the two situational conditions are similar to those proposed for the present study, the design and analyses are such that their differential influence on behavior is not discernible.

Warner and DeFleur (1969) also looked at the influence of attitude, social distance and disclosure on behavior toward black people. Subjects (whose attitudes had been previously assessed) were mailed a letter asking them to engage in behaviors which either allowed them to maintain status superiority over blacks (e.g., tell them about college life) or behavior that involved a reduction of social status differences between blacks and whites (e.g., going on a date). All subjects were asked to sign a pledge to engage in the described activity or to indicate their refusal. In addition, each letter indicated that the pledge

action would either be published or kept confidential. Unfortunately, only 23% of the sample returned the letters. However, the available data suggested that low prejudice subjects tended to behave consistently (comply) when their behaviors were anonymous, while high prejudice subjects tended to behave consistently (refuse) when their behaviors were public. Under the public condition, but not under the private condition, low prejudice subjects tended to behave consistently (comply) when the behaviors maintained status differences, while high prejudice subjects tended to behave consistently (refuse) when the behaviors reduced social differences.

Green (1967) also asked subjects to pose for photographs as well as assessing their attitudes. He distributed sketches of the proposed composition of the photos indicating either an all white or an interracial couple and representing four levels of intimacy (social distance). He asked for signed releases for each picture which indicated different potential uses (disclosure). The analysis indicated that (a) subjects with moderately favorable attitudes were more willing to be photographed with a black person than were those with moderately unfavorable attitudes ($p < .01$), (b) subjects were less willing to pose for the photographs portraying a high degree of intimacy with blacks, and (c) this effect of degree of intimacy was slight when the photograph was to have restricted circulation, but was strong when people would see it ($p < .01$).

Green's study therefore indicated that not only are the two factors of social distance and disclosure important, but also that these two factors show significant interactions. In addition, in the literature on public attitudes toward the mentally ill, social distance

scales, as developed by Whatley (1959), have been used extensively to assess the degree of rejection expressed by respondents (Bord, 1971; Phillips, 1966, 1967). These studies indicated that as the level of intimacy of the social situation increases, people's verbal rejection of the mentally ill also increases.

These studies, as well as the racial studies cited previously, suggested that the level of social distance of the interaction influences people's behavior and should be investigated further. In addition, the racial studies, especially that of Green (1967), suggested that the condition of the disclosure of the interaction also influences people's behavior and may interact with social distance. Therefore, these two variables were included in the present investigation.

Characteristics of Mental Patients

Authors such as Rabkin (1975) have suggested many patient characteristics that may influence the public's behavior. However, there has been comparatively little systematic investigation of these variables, and the studies that are available rely almost exclusively on attitude measures as the dependent measure. The characteristics of mental patients that have been suggested to influence the public's behavior are patients' socio-economic status, age, sex, and the visibility, unpredictability and violence of their symptomatic behavior.

Patient symptomatology. Unpredictability is a characteristic which seems to be attributed stereotypically to mental patients (Bord, 1971; Nunnally, 1961; Wilkins, 1977). The public tends to reject disturbed behavior that is socially visible, even if it is not severe in

terms of its incapacitating effects on the patient (Lemkau & Crocetti, 1962; Phillips, 1964). In addition, the more socially threatening the behavior, the greater the expressed social rejection (Blizard, 1970). In fact, Manis, Houts and Blake (1963) found that psychiatrists, as well as the general public, were more influenced by the social visibility of symptoms than by their severity.

Patient sex. There is some evidence that the sex of the patient also influences people's reactions. Chesler (1972) argued that women are more easily labeled as mentally ill because the traditional female role behaviors of help-seeking and distress-reporting lead more naturally to patient roles. In addition, she argued that the double or masculine standard of mental health used by most clinicians allows for great overlap between traditional feminine-role-behavior and sick-role-behavior. However, although women may be more easily defined as mentally ill, women also seem to be tolerated in the community more than males who exhibit similar sick-role-behaviors.

Linsky (1970) developed an "exclusion index" to assess community rejection of deviants. This index utilized the ratio of involuntary to voluntary commitments with high ratios of involuntary commitments indicating high rejection or low community tolerance. He assessed over 1000 first admissions to three state psychiatric hospitals and found that males were more likely to be excluded than females.

Similarly, in a community survey, Phillips (1964) found respondents more ready to reject males than females for exhibiting comparable behavior symptomatic of mental illness. He concluded that it appears to be more acceptable in our culture for women to be ill and to have problems, while men, on the other hand, are expected to exert

more self-control, to be less expressive and more active in coping with the environment.

Patient socio-economic status (SES). There is also evidence that patients' social class (which includes, depending on the study, patients' educational level, income, and/or occupation) influences people's reactions to them. Hollingshead and Redlich (1958) found differences in where, how and how long patients in different social classes were treated by psychiatrists. For instance, they found that insight psychotherapy was applied in disproportionately high degrees to higher status neurotic patients. Although only a small proportion of schizophrenic patients received psychotherapy, patients from the highest socio-economic class received it twice as frequently as patients from the lowest socio-economic class. Schaffer and Meyers' (1954) investigation of an outpatient clinic supported Hollingshead and Redlich's finding that what happens therapeutically to a person who became a patient is, to a significant degree, a function of his social class position. The higher the patient's SES, the greater were his or her chances of being accepted for psychotherapy and of being assigned to a relatively experienced therapist. Thus patient SES seems to influence mental health professionals' behavior, at least in terms of treatment recommendations.

In addition, Bord (1971) used a social distance scale to assess the influence of patients' behavior, social status (occupational prestige) and help-source. He expected an inverse relationship between social class and people's rejection. Although this relationship did appear, it was quite small. However, when the author analyzed subjects' responses to threatening behavior only, he found that relative to the

high status deviant, the lower status deviant was rejected significantly more severely. Linsky (1970), using the exclusion index mentioned earlier, also found that persons from the lowest socio-economic level (those with 0-6 and 7-8 years of schooling) were more likely to be excluded from the community.

Thus, previous investigations have suggested that patients' symptomatic behavior, sex and SES may all influence people's behavior toward them. Although all these factors require investigation, patient SES was chosen for inclusion in the present study, since the strongest evidence to date for this factor's influence has been obtained primarily from studies involving psychiatrists and other mental health professionals. It is important in addition, to determine if the general public is similarly affected.

The factors that were included in this study were subjects' attitudes toward mental patients, subjects' sex, level of social distance of the interaction, disclosure of the interaction and patient SES.

Behavioral Assessment

Wicker's 1969 summary article demonstrated that experimental evidence does not support the assumption that people's attitudes perfectly reflect or accurately predict their behavior. Partly in response to Wicker's article, investigators have made greater attempts to gather more direct information about people's actual behavior. Where feasible, such as for voting behavior (Sample & Warland, 1973) or church attendance (Wicker, 1971), records or direct observations are becoming much more commonly employed. However, the direct observation and measurement

of complex social interactions is extremely difficult and many practical and statistical problems are encountered.

First, the presence of an observer is quite likely to influence subjects' behavior, either because of demand characteristics or because of inhibition (Campbell & Stanley, 1963; Mercatoris & Craighead, 1974; Roberts & Renzaglia, 1965). Secondly, observers' awareness of expected findings often results in biased observational data (Rosenthal, 1966; Rosenthal, Friedman, Johnson, Fode, Shill, White & Vikan-Kline, 1964). Also, observers' familiarity with subjects, their awareness that a reliability check is being carried out and the complexity of factors observed all greatly influence the reliability of observational data (Kent & Foster, 1977). Further, Heberlein and Black (1976) have argued that many studies use experimental procedures that provoke the behavior through direct intervention or even solicitation by the experimenter. In addition, direct observational measurement poses many practical difficulties. Unless the behavior is restricted to a specific, stable physical setting, measurement is virtually impossible. It is also extremely difficult to identify and control all the factors that may be influencing the behavior in question. The time and cost required by observational measurement of social behavior in naturalistic settings is also prohibitive. Finally, many studies of social behavior assess people's reactions in terms of overt acceptance or avoidance. The dichotomous nature of the data, especially if used in a multivariate design, greatly weakens statistical power. Few standardized situations have been developed that enable investigators to quantify, on a graduated continuum, the acceptance-avoidance behavior to subjects while other conditions and factors are consistently controlled.

Therefore, due to the statistical, practical and ethical restrictions of direct, overt behavior measurement, investigators have attempted to develop alternative procedures that still provide information about people's actual behavior. Several investigators of social interactions (DeFleur & Westie, 1958; Linn, 1965; Warner & DeFleur, 1969) have asked subjects to indicate their willingness to engage in various activities by signing an agreement or commitment statement or by rating their intentions on a scale of comparison. In a review article, Fishbein and Ajzen (1972) defined this type of measure as a Behavioral Intention measure and recommended that this term be used "when the measure employed can be interpreted as placing the subject along a subjective probability dimension involving a relation between himself and some action" (p. 495). In other words, when a subject indicates his intentions or willingness to personally engage in a specific behavior (in relation to an attitude object), the concept of behavioral-intention should be used.

The theory proposed by Ajzen and Fishbein (1970, 1972, 1973) contends that behavioral-intentions (and corresponding overt behavior) are a function of the weighted sum of two components: attitude toward the act and normative beliefs. What is of particular importance for this discussion is that it is assumed that behavioral intentions are highly predictive of actual behavior. In their 1973 article, these authors reviewed the relationship between behavioral-intentions and overt behavior examined in seven studies (although two of these obtained only a self-report measure for the overt behavior score).

Four of these studies (Ajzen, 1971; Ajzen & Fishbein, 1970; Fishbein, Ajzen, Landy & Anderson, 1970; Hornik, 1970) dealt with

Prisoner's Dilemma or other game-task situations. Correlations between intended game behavior and actual game behavior were as follows:

Fishbein et al. (1970)

Communication behavior	.690*
Compliance behavior	.291*
Ajzen & Fishbein (1970)	.879*
Ajzen (1971)	.822*
Hornik (1970)	.867*

(* $p < .01$)

Fishbein (1966) investigated undergraduates' intentions to engage in premarital sexual intercourse. Subjects rated both their general intentions to engage in premarital intercourse and their specific intentions to engage in intercourse during the semester. The behavioral criterion was a self-report taken at the end of the semester. The general intention to engage in premarital intercourse and self-reported behavior correlated .564 ($p < .05$) for female subjects and .174 (ns) for male subjects. The more specific intentional measure correlated somewhat higher with behavior: .676 ($p < .01$) for females and .394 (ns) for males.

Darrouch (1971) investigated subjects' specific behavioral intentions to pose with black and white confederates and subjects' subsequent agreement to have these photos released. Correlations between the number of releases signed and behavioral-intentions varied from .262 to .584 for the different pictures taken, with an average of .461 ($p < .01$).

DeVries and Ajzen (1971) studied students' cheating behavior in college. The correlations between subjects' intentions and

self-reported behavior was .593 ($p < .01$) for cheating in college, .583 ($p < .01$) for copying from others and .781 ($p < .01$) for allowing others to copy from them.

Two other studies have used behavioral-intention measures and determined their relationship to an overt behavior measure. Schwartz and Tessler (1972) assessed subjects' intentions in relation to medical transplant donations and three months later asked subjects to join a pool of potential bone marrow donors. The correlation between these two measures was .375.

Finally, Fendrich (1967) assessed subjects' commitment to engage in various activities with blacks (items varied as to the extent of personal involvement in interracial activities) and later assessed their participation and further interest in discussion groups led by NAACP representatives. The author also varied whether subjects were led to believe they were participating in an experiment or a "real-life" situation. In the experimental condition, the commitment-overt behavior relationship (as measured by Gamma) was low and non-significant (.18). However, in the "real-life" condition this relationship was positive (.72) and significant ($p < .01$).

Thus, presenting the behavioral-intention measure as a real-life, actual commitment seems to increase its usefulness as a behavior measure. To make the behavioral-intention measure reflect a more real commitment, certain investigators have asked subjects to sign their indications of commitment. DeFleur and Westie (1958) have pointed out: "In American society, the affixing of one's signature to a document is a particularly significant act. The signing of checks, contracts, agreements, and the like is clearly understood to indicate a binding

obligation on the part of the signer to abide by the provisions of the document" (p. 670).

The major contribution of these studies is that they provide evidence that behavioral-intention measures can in fact be good predictors of actual behavior. Many studies automatically assume a high behavioral-intention/overt behavior correlation. However, Ajzen and Fishbein (1973) cautioned that several factors influence the degree of correlation between these two measures. First, the longer the time interval between the measurement of the behavioral-intention and the observation of the overt behavior, the lower the probable correlation.

A second important factor relates to the degree of similarity between the hypothetical situation measured by the behavioral-intention scale and the actual real-life situation. When a series of hypothetical situations are rated according to subjects' expressed degree of willingness to interact, subjects can later be asked to participate in one or more real-life situations paralleling the previously presented hypothetical situation, so that their actual behavior may be assessed. The correlation between the behavioral-intention measure and the overt behavior measure will increase according to the degree of similarity between the hypothetical situation (assessed by the behavioral-intention measure) and the actual situation in which subjects participated. The correlation between the overt behavior assessment and the corresponding behavioral-intention score will therefore provide an indication of the appropriateness of using behavioral-intention measures as substitutes for measurements of actual behavior. In any case, any investigation that uses a behavioral-intention measure should attempt to obtain an overt behavior measure to support it, at least until further research

establishes their relationship over a broader range of conditions.

Behavioral-intention measures therefore reflect self-reported willingness to engage in specific, described activities or interactions. This type of measure is not only a good predictor or indicator of actual behavior but it also allows for a series of related conditions or situations to be described so that subjects can indicate their relative willingness to participate in each presented situation.

It is important to note that this type of format is ideally suited for simultaneous investigation of several relevant factors that are assumed to influence people's behavior and for assessing the interactions among factors. For example, two variables each with two dichotomous levels can be combined to make up four different situations. All four combinations can then be presented, so that each subject can indicate his or her willingness to engage in each situation.

The purpose of the present investigation was two-fold. The first purpose was to use a multi-variate design to simultaneously investigate a variety of subject, situational and patient variables that affect people's behavior toward mental patients. This design permitted significant interactions among factors to be detected and interpreted. The second purpose was to develop a practical and effective instrument to measure people's behavior toward mental patients. The practical and statistical problems of direct behavioral measurement have been reviewed previously. There are also ethical prohibitions against placing mental patients in situations where they may be rejected. Thus a behavioral-intention measure was developed to assess subjects' willingness to interact with hospitalized mental patients. This behavioral-intention measure, with an interval six-point scale,

also allows for a design of greater statistical power. In addition, an assessment of subjects' overt behavior was also attempted.

Specifically, this study investigated people's willingness to interact with hospitalized mental patients as affected by two subject characteristics, two situational characteristics and one patient characteristic. The subject characteristics chosen for investigation were subjects' sex and their attitudes toward mental patients. The situational variables were social distance (high and low level of intimacy) and disclosure (whether the interaction would remain private and confidential or whether it would be publicized). The patient characteristic was the reported socio-economic status of the hospitalized mental patient (upper or lower class).

Subjects' willingness to interact with hospitalized mental patients were assessed using a behavioral-intention measure. The two situational factors and the patient factor (each with two levels) were combined so that subjects were presented with eight hypothetical situations to be rated on the behavioral-intention measure. The behavioral-intention measure was presented as a commitment on the part of subjects to engage in some of the specified interactions with hospitalized patients in the near future. To assess the relationship between the behavioral-intention measure and subjects' actual behavior, subjects were invited back, supposedly to engage in one of the interactions specified in the behavioral-intention measure.

The present study was designed to test the following predictions:

1. Subjects who are classified as having more positive attitudes toward hospitalized mental patients on the basis of their scores

on the semantic differential will indicate greater willingness to interact with mental patients, as assessed by a behavioral-intention measure, than will subjects who express negative or neutral attitudes. Similarly, subjects expressing neutral attitudes will indicate greater willingness to interact with hospitalized mental patients than will subjects expressing negative attitudes.

2. Female subjects will express greater willingness to interact with hospitalized mental patients, as assessed by a behavioral-intention measure, than will male subjects.

3. Subjects will indicate greater willingness to interact with hospitalized mental patients, as assessed by a behavioral-intention measure, in hypothetical situations describing interactions of low intimacy as compared to hypothetical situations describing interactions of high intimacy.

4. Subjects will indicate greater willingness to interact with hospitalized mental patients, as assessed by a behavioral-intention measure, when the hypothetical interactions are described as confidential as compared to when the hypothetical interactions are described as being potentially publicized.

5. Subjects will indicate greater willingness to interact with hospitalized mental patients, as assessed by a behavioral-intention measure, when the patients are described as having an upper socio-economic status as compared to when they are described as having low socio-economic status.

In addition, the following predictions concerning the relationship between subjects' expressed willingness to interact with hospitalized mental patients (behavioral-intention score) and their overt

behavior (overt behavior score) were also tested:

1. There will be a positive, significant relationship between subjects' total behavioral-intention score (TBI-each subject's behavioral-intention score summed across all eight hypothetical situations) and subjects' overt behavior score, as measured by Gamma.

2. There will be a positive, significant relationship between subjects' specific behavioral-intention score (SBI-each subject's behavioral-intention score for the situation described by the experimenter over the phone) and subjects' overt behavior score, as measured by Gamma.

3. There will be a positive, significant relationship between subjects' attitude score (as assessed by the semantic differential) and their overt behavior score.

METHOD

Subjects

Subjects were 45 male and 45 female undergraduate students attending the University of Rhode Island (Total = 90). All subjects were volunteers and received neither payment nor credit for their participation. Subjects filled out a questionnaire during regular class time. All subjects were students taking lower division, introductory courses in Sociology, Botany or Chemistry. These courses were chosen because they are typically used to fill area requirements and were therefore attended by many non-majors. This was done so as to avoid the potential bias of having a high percentage of Psychology majors in the sample, since students planning a career in Psychology might show more willingness to interact with hospitalized mental patients.

The average age of the 90 subjects was 19.2 years, with a range of 18-25. The average age of male subjects was 19.4 and the average age of female subjects was 18.9. Seventy-four percent of the subjects were 18 or 19 years old. Although all four college grades were represented in the sample, freshmen comprised 71% of the sample and sophomores comprised 13%. Subjects indicated a wide variety of declared or intended majors with the following breakdown: College of Arts and Science: B.A.--16, B.S.--17; College of Resource Development: 16; College of Engineering: 6; College of Home Economics: 7; College of

Nursing: 3; College of Pharmacy: 17; No major declared: 8. Only five subjects indicated Psychology as their major.

Thus, subjects were, for the most part, relatively new members of the university community who were planning to pursue a wide variety of careers.

Instruments

Semantic differential. The semantic differential has been used to measure attitudes toward many groups of people (Jaffee, 1967; Osgood, Suci & Tannenbaum, 1957; Snider, 1962) as well as mental patients (Nunnally, 1961; Olmstead & Durham, 1975; Wilkins, 1977).

Osgood, Suci and Tannenbaum (1957) maintained that the semantic differential can provide a basis for the quantitative indexing of attitudes. They reported that the Evaluative scale accounts for approximately three-fourths of the common (extracted) variance and approximately 50% of the total variance. It is the evaluative dimension which most clearly reflects attitudes and Evaluative scales are often used as a general measure of attitude. These authors state: "To index attitude we would use sets of scales which have high loadings on the Evaluative factor" (p. 191).

Widespread use of the semantic differential indicates that it is a reliable and valid means of assessing attitudes. Osgood, Suci and Tannenbaum (1957) reported test-retest reliability of .85 for 40 items that were repeated at the end of a 1000 item semantic differential questionnaire. In a separate study, these authors asked 50 subjects to rate three concepts using five evaluative sub-scales. Two weeks later subjects again took the same test. The authors reported test-retest

coefficients of .83, .87 and .91 for the three concepts. Test-retest reliability was also reported by Tannenbaum (1953) using a semantic differential consisting of six concepts with six evaluative scales on two separate occasions separated by five weeks. The test-retest coefficients ranged from .83 to .93 with a mean coefficient of .91.

Osgood, Suci and Tannenbaum (1957) contend that the evaluative dimension of the semantic differential displays reasonable face-validity as a measure of attitude since there is a pervasive evaluative factor in human judgment of others. In addition, these authors compared semantic differential evaluative scales with Thurstone attitude scales. Product-moment correlations for various concepts ranged between .74 and .81 and all correlations were significant ($p < .01$). An unplanned comparison between three evaluative semantic differential scales and a Guttman-type scale was also reported by these authors. The rank order correlation between these two instruments was significant ($\rho = .78$; $p < .01$). Osgood, Suci and Tannenbaum (1957) concluded that these studies "support the notion that the Evaluative factor of the semantic differential is an index of attitude" (p. 194).

For the present investigation, the concepts "Hospitalized Mental Patient" and "Insane Person" were each rated on the following five Evaluative scales: good-bad, pleasant-unpleasant, valuable-worthless, kind-cruel, relaxed-tense.

In addition, subjects rated six other concepts (using the same five Evaluative scales): "Physician," "Teacher," "Russian," "Canadian," "Criminal" and "Retarded Person." Only the two concepts of "Hospitalized Mental Patient" and "Insane Person" were used in the present study but they were embedded among the other concepts in order to

decrease the demand characteristics of the testing situation.

Following Osgood, Suci and Tannenbaum (1957), only Evaluative scales were used since these scales provide the most accurate index of attitudes. The first four scales mentioned have loadings on the Evaluative scale of .75 or better and these four scales are "purely" evaluative in the sense that the extracted variance is almost entirely on the Evaluative scale. The "relaxed-tense" scale is still clearly an Evaluative scale (loading = .55) but there is some positive, although small, loading on the Potency scale as well (loading = .12).

The notion of a continuum between the polar adjectives was made explicit by placing adverbs beneath each position on the seven-point rating scale. In order to guard against response set, the polarity of the scales was randomized so that the positive poles did not always appear at one end of the scale. For purposes of scoring consistency, the score of one was assigned to all "negative" poles of the scale (i.e., bad, unpleasant, worthless, cruel and tense) and the score of seven was assigned to all "positive" poles (i.e., good, pleasant, valuable, kind and relaxed). Individual subject's attitude scores were computed by combining the scores for both of the concepts (summed across all five scales for each of the concepts). Attitude scores therefore could range between 10 (negative) and 70 (positive).

See Appendix A for an example of the questionnaire that includes the semantic differential.

Behavioral-intention measure (BI). The behavioral-intention measure consisted of eight hypothetical situations involving contact with hospitalized mental patients in which subjects rated their degree of willingness to interact with hospitalized mental patients in the

described situations on a six-point scale. Following Warner and DeFleur (1969) subjects were also asked to sign each pledge in order to increase their sense of commitment to participate.

The two levels of social distance (high and low intimacy), the two levels of disclosure (private and public) and the two levels of patient socio-economic status (upper and lower) were combined to produce the eight hypothetical situations. The factors of social distance, disclosure and patient socio-economic status were operationalized as follows:

A. Social Distance

Low Intimacy:

I will meet with the patient, and a psychology graduate student also interested in this project, in a room on campus to talk about what it is like to be a student and to attend the University of Rhode Island.

High Intimacy:

I will meet with the patient in a restaurant to talk about the patient's experiences in the hospital and what it is like to attend the University of Rhode Island.

B. Disclosure

Private:

I understand that my name and experience will be kept confidential.

Public:

I understand that I may be interviewed by a reporter from the Providence Bulletin concerning my experiences and agree to allow my name to be published in the subsequent article.

C. Patient Socio-Economic Status (SES)

Upper SES:

The patient is from a well-to-do family and is presently staying in a private, psychiatric hospital.

Lower SES:

The patient is from a rather poor family and is presently staying in a public, state-run psychiatric hospital.

The score of one was assigned to the "extremely unwilling" pole and the score of six was assigned to the "extremely willing" pole. To control for order effects, four forms of the behavioral-intention measure were administered. The order of the eight situations was different on each form.

See Appendix A for an example of the questionnaire that includes the behavioral-intention measure.

Overt behavior measure (OB). In order to determine the usefulness of the behavioral-intention measure as a substitute for overt, observed behavior, subjects were contacted and asked to come in to participate in one of the activities described on the BI measure. If subjects agreed, they were given an appointment time. When they arrived, the experimenter also offered to give subjects information concerning volunteer programs in near-by mental institutions. Thus, subjects' overt behavior, in terms of their willingness to interact with hospitalized mental patients, was divided into four categories. The levels of overt behavior were accorded a score of one through four as follows:

- 1 = Refusal over the phone to participate in activity.
- 2 = Acceptance over the phone to participate but failure to appear at appointment for activity.
- 3 = Presence at appointment for activity but failure to take information concerning volunteer programs.
- 4 = Presence at appointment for activity, plus subject takes volunteer information.

Procedure

The experimenter introduced herself to the undergraduate classes and explained that all participation was totally voluntary. She then passed out the questionnaire containing the semantic differential and the behavioral-intention measure and said:

I would like you to help me in two ways today. First, I am interested in what people think and feel about certain kinds or classes of people. I would like you to indicate your feelings on the first questionnaire.

The experimenter gave the instructions for the use of the semantic differential and waited for all students to complete it. Then she said:

Presently, I am consulting with several psychiatric hospitals throughout the state and I am working with hospitalized mental patients as they prepare for discharge. I am interested in getting an idea of how available students would be to meet and talk with mental patients. The second questionnaire that I have here describes several situations or circumstances and I would like you to indicate your willingness to meet with patients in each of these situations. All of the meetings will take only about one hour of your time. Let me emphasize that I really am interested in setting up some of these meetings and will try to match people's preferences, as you indicate them here, with a pool of patients who have indicated their interest in such a meeting. All of these patients are about your age.

The experimenter gave the instructions for the use of the behavioral-intention measure and waited for all students to complete it. As the questionnaire was being collected, she closed by saying:

I will use the information I've collected here to find out the type of situation that most people seem to be interested in. Then I will be calling some of you individually to describe the situation that has been arranged to see if you are still interested and available. Thank you for your time.

Four hundred twenty-seven questionnaires were initially collected. One hundred thirteen of these had to be discarded. Of these 113, 86 questionnaires were discarded because they lacked either name

or phone number. Since the overt behavior measure required a follow-up phone call, these subjects could not be used in the present study. Twenty-five questionnaires were discarded because items were skipped or incorrectly filled out. Finally, two questionnaires were discarded because they had been incorrectly assembled by the experimenter.

The remaining 314 questionnaires were then rank ordered according to the attitude score on the semantic differential and divided into three approximately equal groups. The negative attitude group had scores ranging between 15 and 33 ($\bar{X} = 28.6$), the neutral attitude group had scores ranging between 34 and 39 ($\bar{X} = 36.4$), and the positive attitude group had scores ranging between 40 and 62 ($\bar{X} = 44.2$). Fifteen male and fifteen female subjects were then randomly drawn, using random tables, from each of these three attitude groups (positive, neutral, and negative) for a total of 90 subjects.

Approximately two weeks later, the experimenter called each of these 90 subjects individually and described one of the specific situations on the behavioral-intention measure. The situation described was chosen by the following procedure.

The behavioral-intention scores for each of the eight situations were computed across all subjects. Each situation therefore had one general behavioral-intention score. The eight situations were then ranked in order of the total sample's willingness to interact in each situation (from the sample's greatest expressed willingness to interact to the sample's greatest expressed unwillingness to interact). The specific situation that ranked fourth was the one described to each subject. This provided all subjects with a common stimulus while deciding whether to come to the appointment or not. The situation

that ranked fourth and was described was the following:

I will meet with the patient alone in a restaurant to talk about the patient's experiences in the hospital. The patient is from a rather poor family and is presently staying in a public, state-run psychiatric hospital. I understand that my name and experience will be kept confidential.

In order to make the situation appear more realistic, the experimenter specifically explained that the patient wanted to talk with the student in a social situation. Therefore, if the student agreed, the student could meet the patient in the experimenter's office in the psychology building and then walk to a near-by coffee-shop or restaurant.

Once the experimenter had described the situation, she asked the subject to return to engage in that activity. Although no pressure was exerted, the experimenter reminded the subject that only one hour was required of his or her time. The experimenter had an extremely large amount of time available so that inability to schedule a mutually convenient time was never a reason for refusal. Subjects' refusal or acceptance over the phone was recorded.

Subjects who accepted were met by the experimenter when they came for their appointment. The deception was then revealed. The experimenter apologized for the deception and explained the necessity of leading them to believe that the behavioral-intention measure was preliminary to a real contact and that a patient would be waiting to meet them. Every effort was made to have subjects understand the true nature of the experiment. All questions were answered and subjects were encouraged to express their feelings and reactions and to make any comments. The experimenter also explained that three mental institutions in the area had active volunteer programs and interested

subjects were given written information concerning these programs. This information included the names and numbers of the volunteer organizers with whom the experimenter had been in contact (see Appendix B). In addition, subjects were encouraged to contact the experimenter if they became even slightly upset or bothered in the future. Subjects were given a card with the experimenter's home phone and address. Finally, all subjects were given a post-experimental questionnaire to fill out. The post-experimental questionnaire assessed factors influencing subjects' decision to engage in the described activity, subjects' suspiciousness concerning the experimental deception and the possible harmful or adverse effects of the deception (see Appendix C). Subjects were then asked not to talk to anyone about the experiment for three weeks so as not to influence other students who had not yet made their decision.

All subjects who either refused on the phone or agreed to an appointment time but did not show up were then contacted. The experimenter explained the nature of the experiment and asked to meet with each subject at their convenience to discuss the experiment further. If they refused, the experimenter asked to continue over the phone. As with the other subjects, efforts were made to have subjects understand the necessity of the deception and to allow subjects to express their feelings, reactions and concerns. It was emphasized that many people hesitate to interact with hospitalized mental patients and subjects were reassured that discomfort with mental illness is a very usual reaction. The experimenter stressed that the present study was partly directed toward understanding their reactions so that their feelings and decisions were just as important as any other person's who

participated. The experimenter answered any questions that subjects had concerning mental patients, psychiatric hospitals or other related issues. All efforts were made to explore these subjects' reactions toward psychological research, mental patients or their own decisions and behavior in the study. The experimenter's phone number and address was given. The post-experimental questionnaire was also administered.

RESULTS

The variables of subjects' attitude (positive, neutral, and negative), subjects' sex, hypothetical social distance (high intimacy, low intimacy), hypothetical disclosure (private, public), and hypothetical patient socio-economic status (upper SES, lower SES) were analyzed using a $3 \times 2 \times 2 \times 2 \times 2$ analysis of variance with repeated measures across the last three factors.

All tests were performed at the .01 level of significance. With a five-way ANOVA the total number of tests of significance are high so that the probability of obtaining a significant result by chance alone is increased. The stringent alpha level of .01 was therefore chosen to decrease this possibility.

The dependent measure was subjects' behavioral-intention scores. Scores had a possible range of 1 to 6. A score of 1 (one) indicated extreme unwillingness to interact with hospitalized mental patients. A score of 6 (six) indicated extreme willingness to interact with hospitalized mental patients. The means and standard deviations are presented in Table 1. Means ranged between 1.66 and 5.

The Hartley $F_{\max}$ procedure was employed to test the homogeneity of variance. The $F_{\max}$ test was not significant, $F_{\max}(48,14) = 4.293$, $p > .01$, indicating adequate homogeneity among variances.

The analysis of variance (see Table 2) indicated a significant attitude main effect, $F(2,84) = 20.296$, $p < .01$; a significant social

Table 1
Factors Influencing Behavioral-Intentions

		SOCIAL DISTANCE							
		Low Intimacy				High Intimacy			
		DISCLOSURE				DISCLOSURE			
		Private		Public		Private		Public	
		PT. SES		PT. SES		PT. SES		PT. SES	
		Higher	Lower	Higher	Lower	Higher	Lower	Higher	Lower
Means									
MALE									
	Negative	3.600	3.467	2.600	2.400	2.600	2.800	2.000	2.200
	Neutral	3.400	3.267	3.733	3.667	3.333	3.000	3.267	3.333
	Positive	4.400	5.000	4.600	4.800	4.333	4.133	4.133	4.400
FEMALE									
	Negative	3.533	3.333	2.200	2.400	3.000	3.133	1.800	1.667
	Neutral	4.267	4.067	3.600	3.333	3.800	4.067	3.267	3.067
	Positive	4.467	4.667	3.867	3.733	4.267	4.067	3.600	3.667
Standard Deviations									
MALE									
	Negative	1.404	1.407	1.242	1.183	1.242	1.265	0.845	1.014
	Neutral	1.056	1.033	1.223	1.175	1.447	1.000	1.486	1.345
	Positive	1.549	1.000	1.352	1.082	1.496	1.506	1.356	1.183
FEMALE									
	Negative	1.506	1.113	1.656	1.682	1.309	1.598	1.014	0.900
	Neutral	1.280	1.163	1.502	1.496	1.521	1.580	1.751	1.335
	Positive	1.356	1.175	1.187	1.222	1.668	1.668	1.352	1.234

Table 2
Summary Table of Analysis of Variance: Factors Influencing Behavioral-Intentions

Source	Sum of Squares	Degrees of Freedom	Mean Square	F
Sex	0.79956	1	0.79956	0.10708
Attitude	303.09937	2	151.54968	20.29639**
Sex x Attitude	16.50806	2	8.25403	1.10543
Error	627.21362	84	7.46683	
Social Distance	28.00494	1	28.00494	9.57111**
S.D. x Sex	0.55554	1	0.55554	0.18986
S.D. x Attitude	2.20270	2	1.10135	0.37640
S.D. x Sex x Attitude	0.20277	2	0.10139	0.03465
Error	245.78290	84	2.92599	
Disclosure	50.13824	1	50.13824	22.77573**
Dis. x Sex	21.35521	1	21.35521	9.70079**
Dis. x Attitude	22.41887	2	11.20943	5.09198**
Dis. x Sex x Attitude	2.41943	2	1.20972	0.54952
Error	184.91663	84	2.20139	0.54952
Social Distance x Disclosure	0.04999	1	0.04999	0.11767
S.D. x Dis. x Sex	0.08888	1	0.08888	0.20924
S.D. x Dis. x Attitude	0.75832	2	0.37916	0.89257
S.D. x Dis. x Sex x Attitude	1.66942	2	0.83471	1.96497
Error	35.68282	84	0.42480	
Patient SES	0.0	1	0.0	0.0
Pt. SES x Sex	0.27222	1	0.27222	0.75926
Pt. SES x Attitude	1.30832	2	0.65416	1.82457
Pt. SES x Sex x Attitude	0.55276	2	0.27638	0.77088
Error	30.11629	84	0.35853	
Social Distance x Patient SES	0.02222	1	0.02222	0.06301
S.D. x Pt. SES x Sex	0.04999	1	0.04999	0.14178
S.D. x Pt. SES x Attitude	1.50275	2	0.75137	2.13110
S.D. x Pt. SES x Sex x Attitude	1.05830	2	0.52915	1.50082
Error	29.61632	84	0.35258	
Disclosure x Patient SES	0.0	1	0.0	0.0
Dis. x Pt. SES x Sex	0.27222	1	0.27222	1.05133
Dis. x Pt. SES x Attitude	0.00833	2	0.00417	0.01609
Dis. x Pt. SES x Sex x Attitude	0.71942	2	0.35971	1.38924
Error	21.74983	84	0.25893	
Social Distance x Disclosure x Pt. SES	0.20000	1	0.20000	0.78811
S.D. x Dis. x Pt. SES x Sex	0.93887	1	0.93887	3.69975
S.D. x Dis. x Pt. SES x Attitude	2.15831	2	1.07915	4.25254
S.D. x Dis. x Pt. SES x Sex x Attitude	0.13611	2	0.06805	0.26818
Error	21.31642	84	0.25377	

** $p < .01$

distance main effect, $F(1,84) = 9.571$, $p < .01$; and a significant disclosure main effect, $F(1,84) = 22.775$, $p < .01$. The sex main effect and the patient SES main effect were not significant.

In addition, the analysis indicated a significant sex by disclosure interaction, $F(1,84) = 9.700$, $p < .01$, and a significant attitude by disclosure interaction, $F(1,84) = 5.091$, $p < .01$. No other interactions were significant at the .01 level of significance.

Both the disclosure main effect and the attitude main effect must be interpreted in light of the disclosure by attitude interaction. In order to analyze the interaction, the simple effects tests were performed for disclosure at each level of attitude (see Table 3 for means of the interaction). The simple effects test for disclosure at the first level of attitude (negative) was significant, $F(1,84) = 28.653$, $p < .01$; but the tests for disclosure at the second and third level of attitude (neutral and positive) were not significant (see Figure 1). Thus, a significant difference between the public and private level of disclosure was found for students with negative attitudes. Students with negative attitudes toward the mentally ill expressed significantly more willingness to interact with hospitalized mental patients when the interaction would be kept confidential as compared to when the interaction would be publicized. Students with either neutral or positive attitudes did not differ in their willingness to interact with mental patients depending on the potential disclosure of the interaction.

The simple effects tests for attitude at the two levels of disclosure were also performed (see Figure 2). The simple effects test for attitude at the private level of disclosure was significant,

Table 3
Disclosure by Attitude Interaction: Means

	Attitude		
	Negative	Neutral	Positive
Disclosure			
Private	3.183	3.650	4.417
Public	2.158	3.408	4.1

Figure 1. Disclosure by attitude interaction: Disclosure at each level of attitude.

Figure 2. Disclosure by attitude interaction: Attitude at each level of disclosure.

$F(2,168) = 9.627$, $p < .01$, as was the simple effects test for attitude at the public level of disclosure, $F(2,168) = 24.043$, $p < .01$. The Newman-Keuls procedure was employed as the follow-up comparison test (see Appendix D). For the private condition, a significant difference was found between students with positive attitudes and students with either neutral or negative attitudes. No significant difference was found between students with neutral and negative attitudes for the private condition. For the public condition, the Newman-Keuls test indicated a significant difference between students with negative attitudes and students with either neutral or positive attitudes. Students with neutral or positive attitudes were not significantly different at the .01 level of significance. However, these two attitude groups were significantly different when tested at the .05 level of significance, using the Newman-Keuls procedure.

Therefore, the attitude main effect, which was found at both levels of disclosure can be interpreted as a main effect. Students with positive attitudes expressed significantly more willingness to interact with mental patients than students with either neutral or negative attitudes regardless of whether the meeting was to be publicized or kept private. Students with negative attitudes were similar to students with neutral attitudes, in terms of their willingness to meet a patient, only when the interaction was to remain private. When the interaction was to be publicized, however, students with negative attitudes were significantly less willing to meet with a patient as compared to students with neutral attitudes. The disclosure main effect was the result of the difference found for subjects expressing negative attitudes and therefore was not interpreted as a main effect.

The simple effects tests were performed for disclosure at both levels of sex (see Table 4 for means of the interaction). The simple effects test at the first level of sex (Female) was significant, $F(1,84) = 31.123$, $p < .01$, but the simple effects test of disclosure at the second level of sex (Male) was not significant. Thus, female subjects expressed more willingness to interact with mental patients when the interaction was to remain confidential as compared to when the interaction would become public knowledge. Male subjects, however, showed no difference in their willingness to interact with mental patients depending on whether the interaction was to be kept private or publicized.

As stated previously, the analysis also indicated a significant social distance main effect. The mean scores for the two levels of social distance were 3.683 for the low intimacy situation and 3.288 for the high intimacy situation. Students expressed more willingness to interact with hospitalized mental patients in a situation of low intimacy than in a situation of high intimacy.

It should also be noted that the main effect F test for the patient SES factor was approximately zero. Thus, contrary to the author's expectations, patient SES did not emerge as an important factor and had no effect on students' willingness to interact with mental patients.

Relationship of Behavioral-Intention Measure and Overt Behavior Measure

The relationship between the behavioral-intention measure (BI) and the overt behavior measure (OB) was examined in order to determine the usefulness of the behavioral-intention measure as a substitute for

Table 4

Disclosure by Sex Interaction: Means

	Sex	
	Male	Female
Disclosure		
Private	3.611	3.889
Public	3.428	3.017

the overt behavior measure. Three relationships were examined. Firstly, the relation between subjects' total behavioral-intention scores--TBI--(i.e., each subject's behavioral-intention score summed across all eight hypothetical situations) and subjects' overt behavior scores (OB) was computed. Secondly, the relation between subjects' specific behavioral-intention scores--SBI--(i.e., each subject's behavioral-intention score for the situation described by the experimenter over the phone) and subjects' OB scores was computed. Lastly, the relation between subjects' attitude scores and their OB scores was also computed.

The Gamma statistic, a measure of association, which indicates the probability of like ordering, was employed to determine the degree of relationship. The approximate Z test was performed for each Gamma co-efficient to determine if a significant non-zero relationship existed (see Table 5).

Relation of Overt Behavior and Sex of Subject

In order to further explore the overt behavior--attitude relationship, simple contingency tables were developed, including the second between-subject variable of sex. The chi-square test was used to determine, at each level of attitude, whether the frequency of subjects who attended or did not attend the meeting with the mental patient differed depending on subject sex. Thus, the overt behavior categories of one and two (refusal over the phone to participate in the meeting and failure to attend the appointment after verbally indicating they would) were combined to form the non-attendance category. The overt behavior categories of three and four (presence at the meeting

Table 5
Summary Table of Relationships Between Measures and
Associated Tests of Significance

Relationship	Gamma	Z
<u>OB x TBI</u>		
Male Subjects	.414	3.201**
Female Subjects	.421	3.279**
TOTAL SAMPLE	.411	4.731**
<u>OB x SBI</u>		
Male Subjects	.376	2.594**
Female Subjects	.393	3.099**
TOTAL SAMPLE	.416	4.540**
<u>OB x ATTITUDE</u>		
Male Subjects	.382	2.847**
Female Subjects	.469	1.984*
TOTAL SAMPLE	.320	3.433**

** $p < .01$

* $p < .05$

and presence at the meeting with acceptance of volunteer information) were combined to form the attendance category.

For the negative attitude group, the distribution of male and female subjects who attended or did not attend the proposed meeting did not differ significantly ($\chi^2 = .566$; d.f. = 1; $p > .05$). For the neutral attitude group, there was a significant difference in the distribution of male and female subjects who attended and did not attend the proposed meeting ($\chi^2 = 6.65$; d.f. = 1; $p < .05$). Finally, for the positive attitude group, there was no significant difference in the proportion of male and female subjects who attended or did not attend the meeting ($\chi^2 = 0.0$; d.f. = 1; $p > .05$). See Table 6 for contingency tables.

Therefore, there was no significant difference between the proportion of men and women who attended or did not attend the proposed meeting with a mental patient in either the positive or negative attitude group. However, there was a significant difference in the distribution of men and women who attended or did not attend the meeting in the neutral attitude group. Women were significantly more likely to attend the proposed meeting than men, even though both sexes had indicated similar, neutral attitudes toward mental patients.

Sample Characteristics

The sample is an accidental sample rather than a strict, random sample. Therefore, the possibility existed of some inherent bias. Analyses were run to assess the relationship between subjects' behavioral-intention scores and subjects' class level, subjects' age, subjects' reported major and the class in which subjects completed the questionnaire.

Table 6
Contingency Tables of Male and Female Subjects Who
Attended or Did Not Attend Activity

	Attended	Did Not Attend
NEGATIVE ATTITUDES		
Male	5	10
Female	7	8
		$\chi^2 = .566, p > .05$
NEUTRAL ATTITUDES		
Male	3	12
Female	10	5
		$\chi^2 = 6.65, p < .05$
POSITIVE ATTITUDES		
Male	11	4
Female	11	4
		$\chi^2 = 0.0, p > .05$

The relationship between subjects' TBI scores and subjects' class level (freshman, sophomore, junior, senior) was computed using the Gamma statistic of like ordering. The Gamma co-efficient was $-.0005$ and was not significant.

The correlation between subjects' TBI scores and subjects' age was computed using the Pearson product-moment correlation. The correlation was $r = .019$.

A one-way analysis of variance was employed to test the relationship between subjects' TBI scores and the class in which subjects completed the questionnaire (Botany, Sociology, Chemistry). No significant difference among classes was found, $F(2,87) = 1.831$, $p > .05$. See Table 7 for the ANOVA Summary Table.

A one-way analysis of variance was employed to test the relationship between subjects' TBI scores and subjects' reported major. No significant difference among majors was found, $F(6,83) = 2.042$, $p > .05$. See Table 8 for ANOVA Summary Table.

On the basis of the results of these tests, there is no indication that any of these factors were significantly related to the dependent measure.

Post-Experimental Questionnaire

In order to obtain an overt behavior measure, subjects were contacted and asked to come in to meet a hospitalized mental patient. Because of ethical considerations, no patient was actually present so that this process necessarily involved deception. The follow-up questionnaire was designed to assess if the deception was successful, whether there were any harmful effects from the deception and to gather

Table 7

Summary Table of Analysis of Variance:

Class in Which Questionnaire was Completed

Source of Variance	Sum of Squares	Degrees of Freedom	Mean Square	F
Class	303.3750	2	151.6875	1.831
Error	7208.5	87	82.8563	
Total	7511.8750	89		

Table 8

Summary Table of Analysis of Variance:

Reported Major

Source of Variance	Sum of Squares	Degrees of Freedom	Mean Square	F
Major	966.1250	6	161.0208	2.042
Error	6545.750	83	78.8645	
Total	7511.8750	89		

general, anecdotal information regarding other considerations that influenced subjects' decision to engage in the activity with the mental patient.

In response to the question, "Did you know or suspect that this might be for research purposes rather than a 'real' situation?", 19 subjects (21.1% of the sample) responded "yes"; 71 subjects (78.9% of the sample) responded "no." Of the 19 subjects who responded affirmatively, only 3 subjects (3.3% of the sample) had heard of the deception or felt that no patient would be present. The remaining 16 believed they were committing themselves to meet with a patient but believed that data for research was being collected concurrently. These subjects reported that since they were in a university setting, they automatically assumed someone would be studying the phenomenon. Therefore, although 96.6% of the sample believed that they were to meet with a patient, 17.7% of the total sample believed they were meeting a patient in the context of an experiment. These subjects may have felt safer or may have been more concerned about the possibility of evaluation by the experimenter. The effect of this source of variance cannot be assessed.

In response to the question, "Did participation in this study, and especially the deception, make you feel angry or upset in any way?", 9 subjects (10% of the sample) answered "yes"; 81 subjects (90% of the sample) answered "no." Two subjects reported that they were disappointed because they had looked forward to meeting with the patient. Two admitted they were relieved because, prior to the meeting, they had been anxious. Two reported that they were initially upset about the deception but said that they understood and accepted the

reasons that made it necessary. One subject was annoyed because he had awoken for the meeting and did not have a class until noon. One subject did not want to participate and was irritated by the phone calls. Finally, one subject said that he was not upset but his written comments indicated that he felt his integrity was being questioned. The experimenter discussed this with the subject and clarified the intent of the deception. The experimenter gave her phone number to each subject and emphasized that she would like to hear from them if they had any subsequent reactions. No calls were received.

Therefore, the deception did cause some negative feelings on the part of some subjects, although the reactions were relatively non-aversive for the percentage of subjects who were, in some way, affected. No long term effects appear to have developed. However, future studies should make every effort to avoid the deception in order to eliminate the discomfort associated with it.

When deciding whether or not to attend the proposed meeting, 14 subjects (15.5% of the sample) reported that they considered what other people might feel they should do; 76 subjects (85.5% of the sample) did not consider other people's opinions. Two-thirds of the subjects who did consider others' opinions reported that they thought of their friends at the university or at home.

Thirty-seven subjects (41.1% of the sample) reported that they had either worked or knew someone who had been hospitalized in a mental hospital; 53 subjects (58.9% of the sample) reported they had neither worked in nor knew anyone who had been hospitalized. The chi-square test was used to determine whether the frequency of subjects who attended or did not attend the meeting differed depending on subjects'

familiarity with psychiatric hospitals or patients. There was no significant difference in the distribution of subjects who attended or did not attend the meeting depending on their familiarity with psychiatric hospitals or patients ($\chi^2 = .517$; d.f. = 1; $p > .05$). See Appendix E for contingency tables.

The responses to the final question of the post-experimental questionnaire (Question 2) are not easily quantifiable. Question 2 was included only for the purpose of gathering anecdotal data.

DISCUSSION

Since the Mental Health Service Act of 1963 and 1965, increasing numbers of psychiatric patients have been discharged back into communities for continuing treatment. Many communities have reacted negatively to this influx of ex-patients although there are many indications that the public's response has not been uniformly negative. Since the nature of the public's reaction affects the establishment of community facilities, as well as the course of ex-patients' stays in the community, it is clearly important for mental health professionals and community planners to better understand public reaction to mental patients.

However, most of the literature on people's reactions toward mental patients has focused on attitudes of the public rather than its behavior. In addition, it is clear that multiple factors influence behavior so that investigators need to ask, "What types of patients, in interaction with what types of people, in what situations will result in what degree of acceptance or rejection?"

The purpose of the present investigation was two-fold. The first purpose was to simultaneously investigate, through the use of a multivariate design, a variety of subject, situational and patient variables that affect people's behavior towards mental patients. This design permitted significant interactions among factors to be detected and interpreted. The factors investigated were subject sex and attitude

toward mental patients, the social intimacy and potential disclosure of the encounter with the patient and the socio-economic status of the patient. The second purpose was to develop an instrument to measure people's behavior towards mental patients. The behavioral-intention measure was developed to assess people's willingness to interact with hospitalized mental patients.

Behavioral-Intention Measure

The behavioral-intention measure (BI) was developed as a practical and effective way to assess people's willingness to interact with hospitalized mental patients. Since it was a new instrument and a self-report measure, the relationship between the BI measure and the overt behavior measure (OB) was examined in order to determine the usefulness of the BI measure as a substitute for the OB measure. The Gamma co-efficient of .411 for the TBI-OB relationship indicated that there was a 41% probability that subjects' BI score would be in agreement with their OB score.

Although considerable variance is still unaccounted for by this relationship, this magnitude of association is high given that subjects' behavioral-intentions were assessed in a non-laboratory situation. In complex, non-experimental, social situations, numerous variables, which cannot be controlled for, are operable. In such "real-life" conditions, therefore, an association between a behavioral-intention measure and an overt behavior measure of 41% is noteworthy.

In addition, the Gamma co-efficients for the TBI-OB and the SBI-OB relationships were both higher than the Gamma co-efficient for the Attitude-OB relationship. People's behavioral-intentions, as

assessed in this study, are therefore a better predictor of their overt behavior than are their attitudes alone.

In this study, the BI measure required subjects to rate their willingness to engage in an activity with mental patients along a graduated continuum. Such a continuum allows for greater statistical power in a multivariate design than does dichotomous data. The influence of several factors on behavioral-intentions could therefore be simultaneously investigated. In addition, the BI measure assessed people's willingness to interact with a hospitalized mental patient across a variety of situations and conditions. A statistic such as the total behavioral-intention (TBI) score indicates people's generalized willingness to interact with mental patients. This type of score would therefore be less "reactive" to the idiosyncratic variables of one specific situation.

Finally, the use of the BI measure is also justified because it negates the need for deception. In the present study, in order to get an indication of subjects' overt behavior, the experimenter was required to tell subjects that a hospitalized mental patient would be waiting to meet them when, in fact, (due to ethical considerations) none was. Deception such as this should be avoided whenever possible, and the use of the BI measure provides information about people's behavior without necessitating the use of deception.

Factors Influencing Behavioral-Intentions

The two factors that most clearly affected people's willingness to interact with hospitalized mental patients were the degree of social intimacy of the encounter and the attitudes that people held toward

mental patients. People were more willing to meet with mental patients in situations of low intimacy as compared to situations of high intimacy. This finding supports the research by Whatley (1959), Phillips (1966, 1967) and others (Meyer, 1964; Ring & Schein, 1970) that indicated that the public increasingly rejects and isolates the mentally ill as the level of intimacy of the social interaction increases. This finding also parallels the results of studies investigating interracial interactions (e.g., Green, 1967; Linn, 1965; Warner & DeFleur, 1969). These studies suggested that white people were less willing to engage in activities with blacks as the activity became more socially intimate.

The low and high intimacy conditions of the present study differed from each other in three ways: presence or absence of another person, locale of the meeting, and content of intended dialogue. Students found it easier to commit themselves to a situation where another person would be present than when they would be alone with the patient. Meeting in a restaurant was part of the high intimacy situation; a situation with greater social connotations than that of the low intimacy situation in which the meeting was to occur in a campus office. In addition, the low intimacy situation was defined as that in which the patient was interested in learning about "student life," whereas the high intimacy situation indicated that the patient also wanted to discuss his/her own experiences in the hospital. Thus, the locale of the meeting, the content of the discussion and the presence or absence of others all influenced people's willingness to meet with a hospitalized mental patient, although the differential effect of those variables cannot be assessed by this study.

People's attitudes toward mental patients also affected their willingness to meet with mental patients. People with positive attitudes were more willing to meet with patients as compared to people with neutral or negative attitudes regardless of specific aspects of the encounter (e.g., such as the potential disclosure of the meeting). When the meeting was to be publicized, the more positive the attitude held by a person, the more willing was that individual to meet with a patient. However, only students with negative attitudes toward the mentally ill indicated less willingness to meet with hospitalized mental patients when the interaction would be publicized as compared to when it would remain private. The possibility of disclosure did not affect the commitment of students with positive or neutral attitudes. The effect of the type of disclosure on students with negative attitudes may directly reflect their concern over public knowledge of their interaction with stigmatized people whom they hold in low regard. People who themselves stigmatize the mentally ill may therefore fear "stigmatization through association." In addition, it can be assumed that people with negative attitudes toward the mentally ill were more worried about possible negative and unpredictable actions on the part of patients. Given these expectations, they would be more worried about their ability to deal with mental patients and subsequently more concerned with the possibility of the public disclosure. Conversely, people with positive and perhaps neutral attitudes may have been less worried about what could go wrong in the interaction, less worried about their ability to handle the situation and were therefore less concerned about the public disclosure of the interaction.

Female students also expressed more willingness to interact

with mental patients when the interaction was to remain confidential than when the meeting might be publicized. Male students did not indicate differential commitment depending on the disclosure of the meeting. The female students may have been more concerned about or more sensitive to potential censure from significant others if the meeting became public knowledge. However, only 15.5% of the total sample (11.1% of the female subjects) reported that they had considered what other people (friends, parents, faculty) thought they should do when making their decisions. When asked what they did think about, many people reported that they were concerned over what the patient might say or do and reported that they were particularly anxious over whether they would know how to handle any kind of problem or difficult situation that might arise. Many students reported that they had worried about the potential behavior of the patients. Therefore, the author speculates that the influence of whether the activity would be publicized or not does not necessarily reflect people's concern over public knowledge of their interaction with a stigmatized individual. Instead, it may reflect women's concern over the potential public reporting of their ability to cope with difficult interpersonal situations. Men may be more confident that they can in some way handle the interaction or may be less concerned with hurting or harming the patient through the ineffectual handling of the interaction. Women may be more worried about their ability to adequately cope with the imagined difficulties with a mental patient and are therefore more concerned with the possibility of the public disclosure of their actions.

Alternately, women may have rejected the encounter that was to be publicized not because they were worried about the exposure of their

interpersonal abilities but rather because they did not want to be interviewed by a reporter. Women may have viewed the meeting as a personal matter and the publicity carried an exploitative connotation for them. Women may have believed that the publicity would have turned what should be a sensitive, interpersonal encounter into a "public show." Finally, it is also possible that this result simply indicates that women, as compared to men, were more unwilling to be interviewed by a reporter, regardless of the content of the interview.

When subjects' reactions to the experimenter's request that they engage in an activity with a mental patient was further examined, another sex difference emerged. Women with neutral attitudes toward mental patients, once contacted by the experimenter, were more likely to attend the activity, whereas men with neutral attitudes were less likely to attend. However, both men and women with positive attitudes were more likely to attend the activity and both men and women with negative attitudes were less likely to attend. Thus, when people hold strong attitudes either way, attitude seems to help determine their behavior. However, when people's attitudes are more neutral, then other intervening factors may exert a greater influence on subsequent behavior.

Assuming that a neutral attitude indicated ambivalence on the part of people in the neutral attitude group, the personal contact by the experimenter may have been more reassuring to women, thus allowing them to "risk" the activity. The fact that the experimenter was also female may have provided further encouragement and reassurance that they could cope with the situation. The author speculates that when women were personally contacted by the experimenter, they were more

concerned than men with responding in the socially acceptable way and were therefore more likely to comply. Furthermore, relating to and helping people are characteristics typically seen as feminine in this culture. These factors may have influenced more women to attend the activity than men in the neutral attitude group.

It should be noted that the last factor, patient socio-economic status (SES) was not significant, contrary to the author's expectations. Not only was this factor not significant but it contributed no variance to the dependent measure. Patients' SES in no way influenced subjects' commitment to meet with hospitalized mental patients. There is a possibility that this factor was simply not attended to, either because it was embedded in the middle of the paragraph describing the situations, or because the other two variables (social distance and disclosure) were relatively more salient. In addition, the student bodies of universities are generally comprised of students from a wide variety of social, racial and economic backgrounds. Such diversity may promote norms which make discrimination on the basis of economic background less likely. In any case, unlike mental health professionals, such as psychiatrists (Hollingshead & Redlich, 1958; Schaffer & Meyer, 1954), students' behavior towards mental patients is not influenced by patients' SES.

Although a significant subject sex by disclosure interaction was found, the author's prediction that subjects' sex would be found as a significant main effect was not supported. The finding of no sex difference, therefore, tends to support earlier research which found no relationship between attitudes and sex (Lamy, 1966; Nunnally, 1961; Whatley, 1959). Later research by Farina, Felner and Boudreau (1973)

which did suggest a relationship between subjects' sex and behavior toward mental patients, however, did not adequately control for the sex of the patient. Therefore, it may be primarily important to study people's sex as it interacts with other variables. For example, patient sex was not specified in this study. In a subsequent study of similar design (Wilkins, 1979), this author found a significant interaction between subjects' sex and patient sex as well as a significant three-way interaction between subject sex, patient age and etiology of the disorder. It is the author's opinion that in any study of people's behavior toward the mentally ill, subjects' sex should continue to be included.

The BI-OB Relationship--Comparison to Previous Research

The relationship between the behavioral-intention (BI) measure and the overt behavior (OB) measure, as measured by Gamma, indicated a 41% chance that subjects' score on the BI measure would be in agreement with their score on the OB measure. The magnitude of this relationship is smaller than some of the BI-OB relationships reported by Ajzen and Fishbein (1973). Ajzen and Fishbein, as well as other investigators (Darroch, 1971; Schwartz & Tessler, 1972), have compared the BI and OB scores using correlation co-efficients. Fendrich (1967) is one exception to this, using the more appropriate Gamma statistic. It should be noted that the highest correlations reported by Ajzen and Fishbein, those higher than .80, were for correlations between intended game behavior and actual game behavior. Obviously, this type of situation is significantly less complex than the type of social interaction investigated in the present study. In addition, Ajzen and Fishbein reported

that two conditions influence the degree of the BI-OB relationship. They reported that the correlation will be higher if: (a) the time between the statement of intention and actual behavior is short, and (b) is there is a high degree of similarity between the situation measured by the BI scale and the actual situation measured by the OB scale. In the game behavior studies reported by Ajzen and Fishbein, the time between the assessment of the BI and OB measures was very short and the similarity between the two situations was extremely high.

The studies that dealt with more "real" and complex phenomena typically reported lower BI-OB correlations. Schwartz and Tessler (1972) studied people's intentions to donate organs for medical transplants. The correlation between subjects' intentions and their actual behavior was .375. Thus, the BI measure accounted for approximately 14% of the variance of the OB measure. Two further studies are more similar to the present one in that they involved complex social interactions with "stigmatized" individuals, in these cases blacks. Darroch (1971) reported BI-OB correlations ranging between .262 and .584, with an average of .461. Thus, the BI measure accounted for approximately 21.5% of the variance of the OB measure. When investigating intentions and behaviors toward blacks, Fendrich (1967) also varied whether subjects believed they were really being asked to participate in interracial activities or believed they were just participating in an experiment. The BI-OB Gamma co-efficient for the experimental condition was .18; for the "real-life" condition the co-efficient was .72. Thus, in the "real-life" condition, there was a 72% chance that subjects' score

on the BI measure would be in agreement with their score on the OB measure.

The BI-OB relationship found in the present study is notably higher than the BI-OB relationship as reported by Schwartz and Tessler (1972) and Darroch (1971) but lower than that found by Fendrich (1967) for the "real-life" condition. The subjects in the present study may not have felt that they would necessarily be called and asked to participate, since the BI measure was administered in large classes and realistically that many contacts could not be practically arranged. In addition, the time span between the BI-OB measure in Fendrich's study was only five days, whereas in the present study the time span was approximately two weeks. Thus, the lower BI-OB relationship found in this study (as compared to that reported by Fendrich) may be due to differences in both the amount of time between the BI and OB assessments and the extent to which subjects perceived the BI measure to represent an actual, "real-life" commitment to engage in the specified interactions.

As stated previously, Ajzen and Fishbein (1973) reported that the BI-OB relationship will vary depending on the degree of similarity between the hypothetical situation assessed by the BI measure and the actual situation in which the overt behavior is observed. Accordingly, this author expected a higher relationship to exist between the OB score and the specific behavioral-intention score, SBI (i.e., each subject's behavioral-intention score for the situation described by the experimenter over the phone) than between the OB score and the total behavioral-intention score, TBI (i.e., each subject's behavioral-intention scores summed across all eight hypothetical situations).

However, contrary to this expectation, the SBI-OB and TBI-OB relationships were very similar, producing gamma co-efficients of .416 and .411 respectively. The similarity between these two relationships may be due to the fact that many subjects had possibly reached their decisions about their involvement before anything about a specific situation was described to them. In addition, when the experimenter called subjects to ask them to meet with a patient, many subjects made up their minds and responded before the experimenter had completely described the situation. Thus, a certain proportion of subjects only heard that the high-intimacy situation (meet alone in a restaurant) was being offered. They did not wait to hear about the other aspects of the situation. Thus, in addition to the likelihood that some subjects had made their decisions prior to a description of any specific situation, it also appears that other subjects made their decision on the basis of the intimacy variable alone. These two reasons may have contributed to the unexpected similarity of the SBI-OB and the TBI-OB relationships.

It should also be noted that the very act of stating one's intentions (in a BI measure) and later being put in the position of engaging in some behavior described in the BI measure may increase the association between the BI and OB scores. It can be assumed that people remember their stated intentions and will try to maintain consistency between their intentions and overt actions.

In spite of the fact that the BI-OB relationship found in this study is within the range reported by other authors (Darroch, 1971; Fendrich, 1967; Schwartz & Tessler, 1972), there still exists a substantial and important discrepancy between subjects' intended behavior

and their actual, overt behavior. There are clearly many factors that influence people's behavioral intentions and their overt behavior that were not included in the present investigation. For example, patient age or sex, the nature of their disorder or the visibility of their symptoms were not specified in this study. Since these variables were not controlled for, subjects may have made idiosyncratic assumptions about these and other aspects and based their decisions on these assumptions. Ajzen and Fishbein (1972) proposed that people's normative beliefs (social norms regarding the behavior in question) is an important predictor of behavioral intentions and, subsequently, overt behavior. This variable was not included in this study.

Finally, there are many sources of uncontrolled variance that arise between the time the behavioral intentions are assessed and the time that the actual behavior is observed. Many subjects seemed to have been aware that they changed their minds. Some students reported that they were initially interested but no longer had the time, did not like the idea anymore, or something unexpected (like an illness in the family) had come up. Conversely, some students reported that they became more interested after they talked to friends, had time to think about their initial reactions, or their anxiety about the experience had decreased.

The present investigation has drawn on Ajzen and Fishbein's use of behavioral-intention measures as a substitute for and as a means of assessing overt behavior. However, the models and designs used by this author and Ajzen and Fishbein are very different. Ajzen and Fishbein's model for predicting behavioral-intentions and hence overt

behavior proposes that an individual's intention to perform a behavior is a joint function of his attitudes toward the action in question and his beliefs about what others expect him to do (normative beliefs). Other variables may influence behavioral intentions but only indirectly by influencing one of those two components. The relative importance of these two components is expected to vary depending on the conditions under which the behavior is to be performed and depending on the person who is to perform the behavior.

Although the present investigation also uses the concept of behavioral intentions, it approaches all potentially influential variables as independent factors which may affect behavior either directly or in interaction with other variables. The conditions under which the behavior is performed (situational characteristics) and the person performing the behavior (subject characteristics) are two of the categories of potentially important variables that require investigation. Since this study is concerned with social interactions, a third category (not included in Ajzen & Fishbein's model) is object characteristics of mental patients.

More significantly, a multivariate model, such as the one used in the present study, allows one to assess the influence of several factors on behavior as well as to investigate the significant interactions between variables. Interactions between variables are particularly important in complex social encounters where not only are there numerous determining factors but also where some variables may only be significant in interaction. An example of this may be subjects' sex. The relative influence of several variables can be assessed even though other uncontrolled variables are also determining subjects' behavioral

intentions and overt behavior. Through a systematic series of similarly designed studies the major factors and interactions can therefore be determined.

Generalizability of Results

There are three characteristics of the sample used in the present study which may limit the generalizability of results from the student sample used to the general public. The first is that the sampling procedure may have resulted in a sample with an inflated percentage of subjects who were generally willing to interact with hospitalized mental patients. One hundred and thirteen of the original 427 questionnaires had to be discarded. Of these 113, 50 were discarded because they lacked subjects' name; 36 were discarded because they lacked subjects' phone number. A space was left for subjects' name on the first page of the questionnaire. Since the first instrument of the questionnaire was the semantic differential, subjects' refusal to give their name cannot be taken as an indication of subjects' unwillingness to interact with hospitalized mental patients. This refusal more likely reflects subjects' desire to remain anonymous. However, subjects' phone numbers were requested on the behavioral-intention measure itself. Therefore, this refusal may reflect subjects' unwillingness to engage in any activity with hospitalized mental patients. The 36 questionnaires discarded due to lack of phone number constitutes 8.5% of the total sample of 427. To this extent, the present sample may be biased in the direction of increased willingness to interact with hospitalized mental patients.

The second issue concerning generalizability of results is the

possibility of inherent differences between volunteer and non-volunteer subjects. Jung (1971) reviewed this literature and reported that some research had indicated that volunteers do differ from non-volunteers in terms of certain personality variables. It is important to note, however, that a variety of methodological problems render such conclusions about volunteers questionable. In addition, although personality characteristics are assessed in these studies, there is usually no subsequent attempt to compare the two groups (volunteer and non-volunteer) on the basis of their performance in actual experimental situations. What effects these personality variables have on actual behavior in experimental situations, therefore, has not been adequately documented. Finally, present ethical standards prohibit the use of non-volunteer subjects.

For these reasons, volunteer subjects were considered to constitute an acceptable sample for the present study. Given the limitations of volunteer subjects cited previously, however, caution should be exercised when generalizing from the present study to the general public.

Finally, there is a possibility of inherent differences between college students and the general public. College students are obviously younger and have a higher educational level than the general public. However, experimental evidence suggests that, at least in terms of attitudes toward mental patients, student attitudes do not differ significantly from those of the general public (Nunnally, 1961; Olmsted & Durham, 1976). The relative influence of various factors affecting students' behavior may also generally parallel that of the public, although this is an assumption that awaits empirical validation.

In addition, the present sample is a comparatively heterogeneous group which, like the general public, can be considered to have little formal knowledge of psychology and no special career-related interest in the mentally ill. Despite parallels between college student samples and the general public, however, the use of college students as subjects limits to an unknown extent the generalizability of results to the general public. Such limitations must be kept in mind when interpreting the results.

However, college students, regardless of their relationship to the general public, are an interesting and important population to study. They are likely, during their college careers, to find themselves in situations where contact with mental patients is possible. More importantly, it is a population of interest because it is likely that the future body of policy and decision makers of communities (i.e., some of the most important determinants of societal response and priorities) will be largely comprised of college graduates.

Implications for Community Psychology

Although the behavioral-intention measure does not perfectly predict overt behavior, it is a relatively efficient, low-cost procedure that can be used by mental health planners to assess potential public reaction. Not only could this measure be used to assess which situational or patient characteristics would be most acceptable to the public in general, but it could also be used to canvas a specific community. Not all communities may react or be influenced by the same conditions in the same way. A BI measure could be used to estimate specific situational and patient characteristics that would make it

easier for a particular community to accept a new program or half-way house.

The BI measure could also be used as part of a promotional or educational probe into a community. The use of the BI measure as a basis for individually contacting residents in one geographical area before plans for a program had been drawn up might be a non-reactive way of approaching residents. In addition, the BI measure would identify those residents who were particularly favorable toward or particularly antagonistic to a program or to hospitalized mental patients in general. Residents at both extremes could then be contacted. Those residents who were extremely favorable could be enlisted to help plan programs or to help work with other residents. Extremely antagonistic residents could be contacted in order to discuss their complaints and concerns. Finally, since people tend to want to keep their intentions and overt behavior consistent, the BI measure might also be adapted to actually increase the public's willingness to accept mental patients or at least to meet with them. By creating conditions where people responded positively to hypothetical situations on the BI measure, it might be possible to increase the likelihood that they will follow through in actual situations in a similar positive manner.

The results of this study suggest conditions that mental health planners should consider before attempting to re-integrate hospitalized mental patients back into communities. However, this study should be seen as the first in a series of necessary experiments to determine the major factors which influence the public's willingness to interact with hospitalized mental patients, for it is clear that many other factors exist which have not yet been isolated.

First, it is clear that the societal reaction to hospitalized mental patients is not consistently negative. Although it is possible that the response of students may be more positive than that of the general public, many people hold positive attitudes toward mental patients and, in certain circumstances, are willing to interact with them. There is good reason to believe that hospitalized mental patients will encounter friendly and helpful people in the community.

The characteristics of the context of the interaction, however, are important. In order to increase the likelihood of mental patients being accepted they should ideally meet the public in low intimacy, non-threatening situations. Meeting patients in small groups and in safe, somewhat impersonal and structured situations would be likely to increase residents' acceptance. Mental health planners should discourage media involvement and instead attempt to allow residents to make contact with patients in a confidential manner. Before such a meeting, it would be helpful to reassure people that nothing harmful will happen and assure them that they can cope with the interaction. This would be especially important for women and people who held negative attitudes toward hospitalized mental patients. In addition, personal contact by mental health professionals requesting residents to cooperate in a structured activity would also increase the likelihood of residents' participation. This type of personal contact would be especially helpful to women who were ambivalent or neutral in their attitudes toward mental patients and would tend to increase the likelihood of their participation in activities with mental patients. Finally, although it is known that people's attitudes do not directly reflect or predict their behavior, mental health professionals should

not disregard information concerning people's attitudes. Many factors in combination determine people's behavior, but attitude is clearly one factor that does indicate something about the nature of people's actions.

Implications for Future Research

The present investigation had two main purposes. The first was to develop the behavioral-intention (BI) measure as a means to assess people's actual behavior toward mental patients. It is still important, however, to obtain an assessment of overt behavior (OB), if feasible, so that the BI-OB relationship can continue to be examined. The correspondence between two such measures needs to be improved and investigated across a range of conditions.

The major variables affecting their correspondence need to be determined. It is the author's opinion that the BI and OB scores will correspond to a greater degree to the extent that, (a) the time between the two measures is decreased, (b) the similarity between the situations measured is increased, and (c) the subjects believe they are actually committing themselves to engage in the situation described by the BI measure. The belief that the person is actually making a promise to engage in the activity when filling out the BI measure in the affirmative is particularly important. Giving the BI measure in small groups or classes may be one way to create this impression. When administering the BI measure it would also be important for the experimenter to emphasize that he or she is also interested in the reactions of people not particularly willing to meet with patients. This statement might decrease the number of questionnaires that had to be

discarded because of lack of name or phone number.

The second purpose of the study was to investigate several factors that influence people's behavior toward mental patients. This study, however, should be seen as the first in a series of experiments to investigate the numerous factors that affect people's behavior toward mental patients. There is a paucity of such information in the literature. By using a multivariate design not only can the major factors be isolated, but important interactions between factors can be determined. Such interactions are especially important in the investigation of complex, social encounters. Specifically, subject characteristics that need to be investigated are subject age, education and/or SES, normative beliefs and competing motives or attitudes. Situational variables that could be investigated are presence or absence of others, available alternative behaviors and various aspects of the context of the interaction (such as where the meeting takes place or the stated purpose of the meeting). A patient characteristic that is particularly important is patient sex, especially as it interacts with subject sex. In addition, patient age, type of symptomatology, visibility of symptomatology (e.g., whether the patient appears disheveled, whether the patient's speech is coherent and appropriate), and perhaps the label attached to the patient (e.g., hospitalized mental patient, discharged mental patient or emotionally disturbed individual) are all potentially important variables. Further research is therefore required to assess the relative importance of these and other subject, situational and patient variables.

In spite of the numerous difficulties, researchers need to continue to find ways to obtain more information concerning people's

actual behavior toward mental patients. The BI measure was one such attempt. BI-type measures need to be administered to the general public in order to plan how to encourage or increase people's acceptance of mental patients. BI-type measures could be adapted for use in canvassing communities or to find ways to introduce patients to jobs in such a way so as to decrease discrimination.

The general question of this study has been, "What type of patient, in interaction with what type of people, in what type of situations will result in what degree of acceptance or rejection on the part of the public?". It is also necessary to investigate what factors influence, not the behavior of the general public, but rather the behavior of patients once they are living in the community; that is, what factors affect patients' re-adjustment and course of stay in the community? The general question, therefore, becomes, "What types of patients, in interaction with what types of people, in what situations will result in what type of functioning on the part of patients?".

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APPENDIX A

Questionnaire Including the Semantic Differential and Behavioral-Intention Measures

QUESTIONNAIRE # 1

- A. Name _____
- B. Age _____
- C. I am a: 1. _____ Senior
 2. _____ Junior
 3. _____ Sophomore
 4. _____ Freshman
 5. _____ Other
- D. I am a: 1. _____ Female
 2. _____ Male
- E. My major is:
 1. _____ Please Specify
 2. _____ I have not choosen a Major
 2(a). At this moment I expect my major to be:
 _____ Please Specify

* * * * *

The purpose of this questionnaire is to assess people's feelings and thoughts about certain kinds and classes of people. You will be asked to rate certain concepts, such as STUDENT, on a series of scales with adjectives on each end. Indicate what YOU think about the classes of people using the adjective scales.

Example

STUDENT

HAPPY

SAD

_____	_____	_____	_____	_____	_____	_____
extremely	quite	slightly	neither	slightly	quite	extremely
			Happy			
			nor			
			Sad			

-2-

If you feel that the concept, eg. STUDENT, is very closely or extremely associated with the adjective at one end of the scale, place a check mark as follows:

<u>HAPPY</u>						<u>SAD</u>
<u>✓</u>						
extremely	quite	slightly	neither Happy nor Sad	slightly	quite	extremely

OR

<u>HAPPY</u>						<u>SAD</u>
						<u>✓</u>
extremely	quite	slightly	neither Happy nor Sad	slightly	quite	extremely

If you feel that the concept is quite closely related to one or other adjective, place a check mark as follows:

<u>HAPPY</u>						<u>SAD</u>
	<u>✓</u>					
extremely	quite	slightly	neither Happy nor Sad	slightly	quite	extremely

OR

<u>HAPPY</u>						<u>SAD</u>
					<u>✓</u>	
extremely	quite	slightly	neither Happy nor Sad	slightly	quite	extremely

-3-

If you feel that the concept is only slightly related to one adjective, place a check mark as follows:

HAPPYSAD

_____	_____	_____	_____	_____	_____	_____
extremely	quite	slightly	neither	slightly	quite	extremely
			Happy			
			nor			
			Sad			

HAPPY

OR

SAD

_____	_____	_____	_____	_____	_____	_____
extremely	quite	slightly	neither	slightly	quite	extremely
			Happy			
			nor			
			Sad			

The direction toward which you check, of course, depends upon which of the two adjectives at the ends of the scale seem most characteristic of the concept you are judging.

If you consider the concept to be neutral on the scale, then you should place a mark in the middle space.

IMPORTANT

1. Please place your check marks in the middle of the spaces.
2. Be sure to check every scale for every concept--Do Not Omit Any.
3. Never put more than one check mark on a single scale.

Please do not worry or puzzle over individual items. It is your first impressions, the immediate "feelings" about the concepts that we want. On the other hand, please do not be careless, because we want your true impressions.

On the next page you will be asked to indicate your impressions, using these adjective scales, of various kinds or classes of people. There will be several adjective scales for each concept. The concept to be rated will appear at the top of each page. Please read all adjectives carefully.

We realize that there are differences between different individuals in any group. We also recognize that you may not be acquainted with persons of certain groups. Therefore, we are only asking you for your general impressions. Please indicate what you think and feel about a typical person of that group or that group in general. Please indicate YOUR feelings.

CRIMINALGOODBAD

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Good nor Bad	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
------------------	--------------	-----------------	--------------------------------------	-----------------	--------------	------------------

UN-
PLEASANTPLEASANT

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Pleasant nor Unpleasant	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
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KINDCRUEL

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Kind nor Cruel	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
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WORTH-
LESSVALUABLE

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Valuable nor Worthless	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
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RELAXEDTENSE

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Relaxed nor Tense	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
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RUSSIANGOODBAD

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Good nor Bad	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
------------------	--------------	-----------------	--------------------------------------	-----------------	--------------	------------------

UN-
PLEASANTPLEASANT

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Pleasant nor Unpleasant	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
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KINDCRUEL

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Kind nor Cruel	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
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WORTH-
LESSVALUABLE

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Valuable nor Worthless	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
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RELAXEDTENSE

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Relaxed nor Tense	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
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INSANE PERSONGOODBAD

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Good nor Bad	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
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UN-
PLEASANTPLEASANT

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Pleasant nor Unpleasant	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
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KINDCRUEL

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Kind nor Cruel	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
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WORTH-
LESSVALUABLE

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Valuable nor Worthless	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
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RELAXEDTENSE

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Relaxed nor Tense	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
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RETARDED PERSONGOODBAD

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Good nor Bad	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
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UN-
PLEASANTPLEASANT

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Pleasant nor Unpleasant	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
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KINDCRUEL

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Kind nor Cruel	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
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WORTH-
LESSVALUABLE

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Valuable nor Worthless	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
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RELAXEDTENSE

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Relaxed nor Tense	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
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PHYSICIANGOODBADextremelyquiteslightly
neither
 Good
 nor
 Bad
slightlyquiteextremelyUN-
PLEASANTPLEASANTextremelyquiteslightly
neither
 Pleasant
 nor
 Unpleasant
slightlyquiteextremelyKINDCRUELextremelyquiteslightly
neither
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 nor
 Cruel
slightlyquiteextremelyWORTH-
LESSVALUABLEextremelyquiteslightly
neither
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 nor
 Worthless
slightlyquiteextremelyRELAXEDTENSEextremelyquiteslightly
neither
 Relaxed
 nor
 Tense
slightlyquiteextremely

HOSPITALIZED MENTAL PATIENTGOODBADextremelyquiteslightlyneither
Good
nor
BadslightlyquiteextremelyUN-
PLEASANTPLEASANTextremelyquiteslightlyneither
Pleasant
nor
UnpleasantslightlyquiteextremelyKINDCRUELextremelyquiteslightlyneither
Kind
nor
CruelslightlyquiteextremelyWORTH-
LESSVALUABLEextremelyquiteslightlyneither
Valuable
nor
WorthlessslightlyquiteextremelyRELAXEDTENSEextremelyquiteslightlyneither
Relaxed
nor
Tenseslightlyquiteextremely

CANADIANGOODBAD

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Good nor Bad	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
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UN-
PLEASANTPLEASANT

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Pleasant nor Unpleasant	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
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KINDCRUEL

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Kind nor Cruel	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
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WORTH-
LESSVALUABLE

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Valuable nor Worthless	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
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RELAXEDTENSE

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Relaxed nor Tense	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
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TEACHERGOODBAD

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Good nor Bad	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
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UN-
PLEASANTPLEASANT

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Pleasant nor Unpleasant	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
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KINDCRUEL

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Kind nor Cruel	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
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WORTH-
LESSVALUABLE

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Valuable nor Worthless	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
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RELAXEDTENSE

<u>extremely</u>	<u>quite</u>	<u>slightly</u>	<u>neither</u> Relaxed nor Tense	<u>slightly</u>	<u>quite</u>	<u>extremely</u>
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QUESTIONNAIRE # 2

A. Name _____

B. Telephone Number:

School Number _____

Home Number _____

Other Number where
I can be reached _____

*

*

*

*

*

*

*

The purpose of this questionnaire is to assess your availability or willingness to meet with different patients in a variety of situations.

Below a description of each situation, there will be a 6-point scale ranging from "Extremely Willing" to "Extremely Unwilling".

Example

_____	_____	_____	_____	_____	_____
extremely	quite	slightly	slightly	quite	extremely
willing	willing	willing	<u>un</u> willing	<u>un</u> willing	<u>un</u> willing

Indicate your degree of willingness to engage in each activity by checking the appropriate space.

Please place your check in the middle of the space, not on the boundary.

Be sure to check the scale for each situation. Never put more than one check mark for a single situation.

There will be eight situations. Please read ALL EIGHT situations first, BEFORE indicating your willingness. After you have checked each situation, please sign your name in the space provided.

A

I will meet with the patient alone in a restaurant to talk about the patient's experiences in the hospital. The patient is from a well-to-do family and is presently staying in an expensive, private, psychiatric hospital. I understand that my name and experience will be kept confidential.

<u>extremely</u> willing	<u>quite</u> willing	<u>slightly</u> willing	<u>slightly</u> <u>unwilling</u>	<u>quite</u> <u>unwilling</u>	<u>extremely</u> <u>unwilling</u>
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Signature

I will meet with the patient, and a psychology graduate student also interested in the project, in a room on campus to talk about what it is like to be a college student and to attend the University of Rhode Island. The patient is from a rather poor family and is presently staying in a public, state-run psychiatric hospital. I understand that my name and experience will be kept confidential.

<u>extremely</u> willing	<u>quite</u> willing	<u>slightly</u> willing	<u>slightly</u> <u>unwilling</u>	<u>quite</u> <u>unwilling</u>	<u>extremely</u> <u>unwilling</u>
-----------------------------	-------------------------	----------------------------	-------------------------------------	----------------------------------	--------------------------------------

Signature

B

I will meet with the patient, and a psychology graduate student also interested in this project, in a room on campus to talk about what it is like to be a college student and to attend the University of Rhode Island. The patient is from a well-to-do family and is presently staying in an expensive, private, psychiatric hospital. I understand that I may be interviewed by a reporter from the Providence Bulletin concerning my experiences with the patient and agree to allow my name to be published in the subsequent article.

extremely
willing

quite
willing

slightly
willing

slightly
unwilling

quite
unwilling

extremely
unwilling

Signature

I will meet with the patient, and a psychology graduate student also interested in the project, in a room on campus to talk about what it is like to be a college student and to attend the University of Rhode Island. The patient is from a well-to-do family and is presently staying in an expensive, private, psychiatric hospital. I understand that my name and experience will be kept confidential.

extremely
willing

quite
willing

slightly
willing

slightly
unwilling

quite
unwilling

extremely
unwilling

Signature

C

I will meet with the patient, and a psychology graduate student also interested in this project, in a room on campus to talk about what it is like to be a college student and to attend the University of Rhode Island. The patient is from a rather poor family and is presently staying in a public, state-run psychiatric hospital. I understand that I may be interviewed by a reporter from the Providence Bulletin concerning my experiences with the patient and agree to allow my name to be published in the subsequent article.

-----	-----	-----	-----	-----	-----
extremely	quite	slightly	slightly	quite	extremely
willing	willing	willing	<u>unwilling</u>	<u>unwilling</u>	<u>unwilling</u>

Signature

I will meet with the patient alone in a restaurant to talk about the patient's experiences in the hospital. The patient is from a rather poor family and is presently staying in a public, state-run psychiatric hospital. I understand that I may be interviewed by a reporter from the Providence Bulletin concerning my experiences with the patient and agree to allow my name to be published in the subsequent article.

-----	-----	-----	-----	-----	-----
extremely	quite	slightly	slightly	quite	extremely
willing	willing	willing	<u>unwilling</u>	<u>unwilling</u>	<u>unwilling</u>

Signature

D

I will meet with the patient alone in a restaurant to talk about the patient's experiences in the hospital. The patient is from a well-to-do family and is presently staying in an expensive, private, psychiatric hospital. I understand that I may be interviewed by a reporter from the Providence Bulletin concerning my experiences with the patient and agree to allow my name to be published in the subsequent article.

extremely
willing

quite
willing

slightly
willing

slightly
unwilling

quite
unwilling

extremely
unwilling

Signature

I will meet with the patient alone in a restaurant to talk about the patient's experiences in the hospital. The patient is from a rather poor family and is presently staying in a public, state-run psychiatric hospital. I understand that my name and experience will be kept confidential.

extremely
willing

quite
willing

slightly
willing

slightly
unwilling

quite
unwilling

extremely
unwilling

Signature

APPENDIX B

Volunteer Information

BUTLER HOSPITAL

Volunteer Service
Ms. Pat Cole - 456-3776

Many student volunteers
Course credit can be arranged
Preliminary interview with Pat Cole required
Two days of orientation, supervision part of service
Please call even if only want to investigate opportunities

Volunteer Experiences

- Level 1: Research-Evaluation Programs
-Volunteers do not work directly with patients
-Assist in research and in evaluation of hospital treatment programs
- Level 2: Task Oriented Activities in Patient Areas
-Interview patients (for research)
-Tutor adolescents in hospital-based school
-Work in nursing stations
- Level 3: On-going Work with Patients
-Must commit 3-6 months

WARWICK COMMUNITY MENTAL HEALTH CENTER

Volunteer Service
Ms. Faria - 738-4300 ext. 493

Out-patient services only
Interview with Ms. Faria required
Orientation, supervision part of volunteer service
Please call even if only want to investigate opportunities

Volunteer Experiences

- 1) Day-Treatment Program
-Socialization and education programs
-Volunteers assist in activities such as crafts, cooking and day trips
- 2) Friend's Program
-Friend/advocate for people returning from the Institute of Mental Health

APPENDIX C

Post-Experimental Questionnaire

FOLLOW-UP QUESTIONNAIRE

Name _____

1. Did you know or suspect that this might be for research purposes rather than a "real" situation?

YES _____ NO _____

If yes, what led you to believe/suspect?

2. What pressure, if any, did you feel (both pro and con) in deciding whether to come or not?
In other words, what kinds of things did you think about while deciding whether or not to come?

3. When deciding whether to come or not, did you consider what other people might feel you should do?

YES _____ NO _____

If yes, please check as many people as you considered:

- a. _____ Friends here at the University
- b. _____ Friends from home
- c. _____ Parents
- d. _____ Faculty from the University
- e. _____ Others (Please specify)

4. Have you ever worked with or have you ever known anyone who has been hospitalized in a mental hospital?

YES _____ NO _____

5. Did participation in this study, and especially the deception, make you feel angry or upset in any way?

YES _____ NO _____

If yes, please explain further:

If you at any time have any questions, you can contact JOAN WILKINS by leaving a note with the Psychology Department secretaries.

THANK YOU AGAIN FOR YOUR TIME AND EFFORT.

APPENDIX D

Summary Table of Newman-Keuls Tests

Summary Table of Newman Keuls Tests:

Attitude at Each Level of Disclosure

	Negative	Neutral	Positive
<u>PRIVATE</u>			
Negative	--		**
Neutral		--	**
Positive			--

** $p < .01$

	Negative	Neutral	Positive
<u>PUBLIC</u>			
Negative	--	** *	** *
Neutral		--	*
Positive			--

* $p < .05$ ** $p < .01$

APPENDIX E

Contingency Table:

Subjects Familiar or Not Familiar with Psychiatric
Hospitals Who Attended or Did Not Attend Activity

Contingency Table:

Subjects Familiar or Not Familiar with Psychiatric Hospitals
Who Attended or Did Not Attend Activity

	Attended	Did Not Attend
Familiar	21	16
Not Familiar	26	27

$$\chi^2 = .517, p > .05$$