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ETHNIC ATTITUDES TOWARD MENTAL HEALTH AND MENTAL ILLNESS

by

Richard Joseph Muszynski

A Thesis Submitted to the Faculty of the

DEPARTMENT OF PSYCHOLOGY

In Partial Fulfillment of the Requirements
For the Degree of

MASTER OF ARTS

In the Graduate College

THE UNIVERSITY OF ARIZONA

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STATEMENT BY AUTHOR

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ABSTRACT

The Ethnic Mental Illness (EMI) Scale, a questionnaire to discriminate European and Hispanic attitudes toward mental illness, was developed. Fifty-one college students of Hispanic ethnicity and 194 college students of European ethnicity completed a 150 item questionnaire measuring attitudes toward mental illness. A cross-validation sample of 50 Hispanic students and 194 European students ethnicity yielded 15 items that reliably differentiated the two groups. Based upon content, the 15 items were grouped into six categories: hopefulness, trust, biological aspects of mental illness, childhood origins, finances, and sex differences. Items which did not discriminate Hispanics and Europeans are described, as these items are possible indicators of common attitudes toward mental illness. A group of 66 Asian students also participated in the study. The items which differentiate Asians from Hispanics and Europeans are described. These items were not cross-validated.

CHAPTER 1

INTRODUCTION

Conceptions of mental disorders vary across time and culture. Current ideas and understandings of mental disorders differ considerably from the understandings and ideas once held in the past. Also, Western cultural conceptualizations of mental disorders differ from the conceptualizations of other cultures. Even within a culture, attitudes toward mental disorders can vary according to age, occupation, ethnicity, income and education.

The United States is composed of many ethnic groups from cultures all over the world. Given such cultural diversity, the possibility exists that European, Asian, and Hispanic ethnic groups differ in their conceptualizations of mental disorders. For example, differences in views concerning the causes, symptoms and treatment of mental disorders may exist. This study will examine ethnic differences in attitudes toward mental disorders.

Differences in views toward mental disorders among ethnic groups are compounded by acculturation. The dominant view of mental disorders in the U.S. is derived from Western culture. As ethnic groups from other cultures settle in the U.S., their attitudes toward mental disorders may shift closer to the dominant

Western attitude. Thus, the closer an ethnic group is to being acculturated into the American style of life, the more American their views of mental disorders are likely to be. This study will also examine such acculturative issues.

The view an individual holds toward mental disorders has an impact on the course and style of treatment. The implications of ethnic differences in attitudes toward mental disorders for treatment will also be discussed.

Public Attitudes Toward Mental Disorders in the U.S.

The topic of mental disorders is broad. Public attitudes toward mental disorders are thus understandably diffuse and incoherent. Nunnally (1961) found ten factors that characterize attitudes toward mental disorders. These factors are: the mentally ill look and act different than normal people, will power, a sex distinction, avoidance of morbid thoughts, guidance and support, hopelessness, immediate external environment versus personality dynamics, nonseriousness, age, and organic causes. Based on these factors, Nunnally proposed that the information the public has concerning mental disorders lacks structure, people are unsure of their opinions and are likely to change them, the public is not grossly misinformed about mental disorders although some groups in the population are misinformed and that the public lacks information on some aspects of mental disorders.

Nunnally (1961), using the semantic differential technique, also examined public attitudes toward the mentally ill, mental health professionals, and treatment for mental illness. Based on his data, he made the generalizations that: public attitudes are relatively negative toward people with mental health problems, public attitudes are different toward neurotic and psychotic disorders, those with more education hold less derogatory attitudes toward the mentally ill, public attitudes toward mental health professionals are positive, the public places higher evaluations on professionals who treat physical disorders than on professionals who treat mental disorders, the public does not make distinctions among subprofessions in the field of mental health, and the public holds mental health treatment methods and institutions in relatively low esteem.

Different methods of assessing attitudes toward mental disorders yield different results. Cox, Costanzo and Coie (1976) found three factors: personal inadequacy and ineffectiveness, disturbed thinking, and social maladjustment. Cox et al. used a 190 item survey instrument. Most items were taken from the Minnesota Multiphasic Personality Inventory (MMPI). The items were rewritten in the third person, so that subjects could indicate the degree of concern they would have about a person as described in the item. Cox et al. were mostly concerned with the public's attribution of mental illness. The criteria for attributing mental illness were seen to derive from local norms consisting of

community and subcultural standards for behavior and deviance and shared norms independent of particualar group membership.

Public attitudes have been examined in regards to mental health as well as mental illness. Tyler et al. (1983) designed the Mental Health Values Questionnaire (MHVQ) to measure attitudes concerning what attributes constitute good mental health. The MHVQ was a five point Likert rating scale consisting of eight factors: self-acceptance, negative traits, achievement, affective control, good interpersonal relations, untrustworthiness, religiousness, and unconventional experiences.

An abundance of measures patterned in a similar manner as Nunnally's (1961) scale exist. First of all, the Attitudes Toward Mental Illness Scale (ATMI), developed by Froemel and Zolik (1967), consisted of items from previously existing scales and items derived from the relatives of mentally disordered patients and from married couples taking part in a discussion of mental illness. The ATMI was a six point Likert rating scale, which yielded 16 factors, organized into three categories. The first category, attitudes about causes, consisted of the factors: childhood causation, arrested socialization, neural orientation, popular causes and Biblical folklore. The second category, attitudes toward treatment, consisted of the factors: adequacy of treatment, hospital adequacy, progressive awareness, early treatment, sufficiency of an M.D. (general practitioner), authoritarian-custodial treatment, and therapy as guidance. The

third category, attitudes about patients, consisted of the factors: patient-normal differences, patient self-care, fatalistic prognosis and permanent pathology.

As another example, Cohen and Struening (1962) developed the Opinions about Mental Illness (OMI) scales. Fifty-five items on the OMI related to the cause, description, treatment and prognosis of severe mental illness. An additional 15 items were taken from the Custodial Mental Illness (CMI) Ideology Scale, the California F scale and Nunnally's (1961) work on conceptions of mental illness. The 70 items were presented in a Likert format on a six point scale. Cohen and Struening found five factors: authoritarianism, benevolence, mental hygiene ideology, social restrictiveness, and interpersonal ideology. Cohen and Struening (1963), in a study of mental hospital employees, found that white collar workers, nonmedical mental health professionals, clergymen and psychiatrists had low scores on authoritarianism, while blue collar workers and a population of rural Kansas citizens had high scores on authoritarianism. Psychiatrists had low scores on mental hygiene ideology while nonmedical mental health professionals, clergymen and rural Kansas citizens had high scores on mental hygiene ideology. Social restrictiveness scores were high for blue collar workers and nonmedical mental health professionals, and were low for clergymen and psychiatrists. Interpersonal ideology scores were high for nonmedical mental health professionals, and

clergymen. Blue collar workers had low benevolence scores while clergymen had high benevolence scores.

Dielman, Stiefel and Cattell (1973), in a study of the OMI using 138 introductory psychology students found seven factors. These factors were: interpersonal etiology, mental hygiene ideology, social restrictiveness, authoritarianism, medical model orientation, benevolence, and a one item factor relating to the notion that there are more severely mentally ill people who have never been hospitalized than those who are hospitalized. Moore and Castles (1978) found intercorrelations among the factors in the OMI in a study of 692 nonpsychiatric nurses. Significant positive correlations were found between benevolence and mental hygiene ideology, benevolence and social restrictiveness, mental hygiene ideology and social restrictiveness and between authoritarianism and interpersonal etiology. Significant negative correlations were found between authoritarianism and benevolence and between authoritarianism and mental hygiene ideology.

Other measures assessed attitudes toward mental illness from a more limited scope of content. For example, Gilbert and Levinson (1956) developed the Custodial Mental Illness Ideology Scale (CMI). The CMI was designed to measure attitudes toward mental illness on the continuum of custodialism-humanism. The custodial position holds that mental hospitals should be highly controlled settings concerned with the detention and safekeeping of patients who are basically different from normal people. The

custodial position also stresses organic causes of mental illness. The humanistic position holds that the mental hospital should be concerned with the human needs and individuality of patients while stressing interpersonal and intrapsychic causes of mental illness. The CMI consists of 20 items concerning the nature and causes of mental illness, hospital conditions and patient-staff relations. The CMI is scored on a seven point scale, from negative three (strong disagreement) to positive three (strong agreement), with a high score indicating custodialism. The CMI was developed on 335 staff members of three Massachusetts mental hospitals. The mean for this sample was 31.3 and the standard deviation was 9.5. The split-half reliability was found to be .85.

Factor structures of existing scales are frequently found to differ across studies. To determine whether the factor structures of the OMI and CMI remain the same, Wahl, Zastowny and Briggs (1980) studied the attitudes of 228 volunteer literacy teachers and 40 volunteers who work with psychiatric patients. Wahl et al. found that factor analysis of the OMI yielded five factors, two of which replicate the findings of Cohen and Struening (1962): mental hygiene ideology and interpersonal etiology. The three other factors were found to be reassortments of the original factors. They were: fearful restrictiveness, personal inadequacy orientation and authoritarian separatism. The analysis of Wahl et al. of the CMI yielded three factors: custodialism, humanism and paternalism. Wahl et al. suggested the

OMI and CMI continue to assess the same attitude dimensions of mental illness as originally intended, however deviations in the factor structures of each instrument should be considered.

Ahmed and Viswanathan (1984) reexamined the factor structure of Nunnally's (1961) mental health attitude scale. The subjects were 179 college students from Canada. Ahmed and Viswanathan found the inter-item correlation to be .11 and the Cronbach alpha-coefficient of reliability to be .18. Eighteen factors were obtained, which Ahmed and Viswanathan found to be uninterpretable. Ahmed and Viswanathan argue the scale is heterogenous. They imply that the failure of the scale to reflect a coherent definition of mental illness means that the scale is inadequate, the public is uneducated about mental illness, or mental illness is not coherent.

A few studies have been carried out assessing the attitudes of mental patients toward mental illness. Gynther and Brilliant (1964) used the CMI to study the attitudes of 124 psychiatric patients toward mental illness. They found that older, married patients favored custodial care. Also, less educated patients favored custodial care. Finally, the more emotionally disturbed patients expressed more custodial attitudes than less emotionally disturbed patients. Gynther and Brilliant suggested that individuals with reduced internal controls, such as the less educated and more emotionally disturbed, have a greater need for external controls, thus favoring custodial care. Clark and Binks

(1966), in a study of 56 subjects across various age and educational groups, also found that less educated and older people have more custodial attitudes toward mental illness than more educated and younger people, as measured by the CMI.

Manis, Houts and Blake (1963) assessed the beliefs about mental illness among psychiatric patients, medical patients and mental health professionals using Nunnally's (1961) items plus six additional items pertaining to moralistic attitudes about mental illness. The attitudes of psychiatric and medical patients were similar at the start of treatment, except that psychiatric patients were more moralistic than medical patients. Patients with more education and higher IQs generally believed mental patients are like normal people in appearance and that mental illness is curable. The beliefs of the psychiatric patients differed significantly from the beliefs of the mental health professionals, except in regards to sex differences and hopelessness. Manis, Houts and Blake found that after one month of treatment, the beliefs of the psychiatric patients shifted toward the beliefs of the mental health professionals. In addition, psychiatric patients who changed their views more toward the views of the mental health professionals did better in treatment. The psychiatric patients with the longest terms of hospitalization had the most discrepant views from those of the mental health professionals.

Other studies have been performed which measure attitudes of mental illness among different segments of the population. Freeman and Kassebaum (1960) examined the relationship of education and knowledge of mental illness to opinions about mental illness. They used a yes or no format questionnaire which elicited opinions about the etiology and prevention of mental illness and which tested the knowledge of psychiatric terms. Freeman and Kassebaum found low correlations between education and opinions about the etiology and prevention of mental illness and between technical knowledge of psychiatric terms and opinions about the etiology and prevention of mental illness.

Wright and Klein (1966) compared the attitudes toward mental patients between hospital personnel and community residents using the Wright Mental Illness Questionnaire, Form I. They found that hospital personnel were significantly more accepting of mental patients than were community residents. Professional personnel were more accepting of mental patients than were non-professional personnel. The hospital personnel estimated a shorter duration of hospitalization for mental patients than did community residents. In ranking hypothetical causes of mental illness, the hospital personnel and community residents placed the same causes in the top five positions, although in different orders.

Manis, Hunt, Brawer and Kercher (1965) examined public and mental health professionals' conceptualizations of what constitutes mental illness and the troublesomeness of mental illness. Subjects were asked to rate twenty statements in terms of its likelihood to be an indication of mental illness. There were two items pertaining to each of the following types of behavior: aggressive, withdrawn, bizarre, conformist, grandiose, persecutive, manic, depressive, emotional and blunted. Manis et al. found that mental health professionals agreed on what behaviors constitute mental illness and were not concerned with the troublesomeness of the behavior. The attitudes of the public were similar to the attitudes of the mental health professionals except the public was slightly more concerned with the troublesomeness of the behavior.

Giovannoni and Ullmann (1963) used the semantic differential technique to study attitudes of psychiatric patients in regard to the concepts "neurotic man", "average man", "psychiatrist", "insane man", "father" and "me". The concepts "insane man" and "neurotic man" were rated as generally bad, dirty, cold, dangerous, unpredictable and worthless.

Cultural Differences in Attitudes Toward Mental Illness

Fabrega (1982) pointed out that the manifestation of psychiatric illness reflects the culture as well as the biology of an individual. Cultures may vary not only in the way an individual

with a given psychiatric illness expresses this illness behaviorally, but also in regard to what behaviors are disvalued or the concern for which people show for the mentally ill.

White (1982) stated that the language used to descibe and talk about illness varies across cultures and is meaningful to the way a culture views illness. The classification of mental disorders serves the social and clinical function of diagnosis. Cultures may vary on how fuzzy or discrete their classification systems are structured. White further stated that the semantics used to describe mental disorders form culturally relevant attributes about aspects of mental disorders such as causality, symptomatology, treatment, consequences of mental disorders, and the type of people victimized by mental disorders.

White and Marsella (1982) pointed out a number of ways cultures may differ in conceptualizing mental health and mental disorders. For example, some cultures see a distinction between the mind and body, while other cultures see a continuum of the mind and the body. Some cultures see thought and emotion as a continuum, while other cultures see thought and emotion as distinct entities. Emotions can be viewed as intrapsychic or interdependent between the person and environment. The self may be viewed as having sharp or loose boundaries. The cause of mental disorders may be viewed as being intrapsychic or supernatural.

Cultures may see the role of the mentally disordered in society and their responsibility to society in different ways.

Denko (1966) identified four ways that preliterate people explain disturbed behavior. The first set of explanations see disturbed behavior as dating from the past. This explanation includes examples such as prenatal maternal carelessness, inheritance from parents and religious punishment due to the sins of one's forebearers. The second set of explanations see disturbed behavior as dating from the present and external to the afflicted person. This explanation includes examples such as possession, the machinations of ghosts or spirits in ways other than possession, sorcery by shamans or others and noxious environmental factors. The third set of explanations see disturbed behavior dating from the present but indicating the afflicted person. This explanation includes examples such as punishment for the afflicted person's guilt, peregrinations of the soul, and problems with dreaming. The fourth explanation sees disturbed behavior as a result of personality.

Subcultural differences in attitudes toward mental illness have been postulated and studied. Gaines (1982) stated that the Western conception of mental health can be broken down into the Northern European or Protestant conception and the Latin European or Catholic conception. The Northern European conception views the self as unique, bounded, and different from all others. The self is reflective and gains from experience. Thus, therapeutic change

can be based upon insight. In contrast, the Latin European conception views the self as part of contextual features of social interaction. Character or personality is expressed in different, sometimes inconsistent ways depending on the social interaction. Therapeutic change can be based upon spiritual or "magical" processes. Gaines pointed out the need to take into account the cultural context of the patient in clinical encounters, as the views of self can affect the therapeutic process.

Piedmont (1965) suggested that there are levels of causation of mental illness, from the organic to psychological to socio-cultural levels or from intrapersonal to interpersonal levels. Piedmont further suggested that ethnic values, which reflect the culture, are learned early in life. Piedmont suggested that the early life experiences set the foundation for normal or abnormal personality development and socialization. Therefore, ethnicity plays an important role in the expression and attitudes toward mental disorders. He argues for more research investigating the role of ethnicity in mental disorders.

Dohrenwend and Chin-Shong (1967) studied the attitudes of four ethnic groups in New York (Irish, Puerto Rican, Jewish and Black) toward six case descriptions of behavior illustrating paranoid schizophrenia, simple schizophrenia, anxiety neurosis, alcoholism, compulsive-phobic behavior and juvenile character disorder. The Irish and Puerto Rican groups were less likely than the Jewish and Black groups to see something wrong in all six case

descriptions. The Black and Puerto Rican groups had the lowest tendencies to see the described behaviors as serious. The behaviors that the Black and Puerto Rican groups did see as serious were those behaviors which included harm to others. The Jewish group had the greatest tendency to recommend help from the mental health professions. Dohrenwend and Chin-Shong also examined the effect of educational levels. They found the less educated subjects were more likely to have discrepant attitudes from the attitudes of mental health professionals. The less educated were more likely to want hospitalization for the people described in the six cases. The less educated subjects from the Black and Puerto Rican groups advocated the most social distance from mental patients.

Kahn, Jones, MacDonald, Conners and Burchard (1963) developed the Colorado Psychopathic Hospital (CPH) factor scale to determine attitudes toward mental illness and psychiatric hospitalization. The CPH factor scale consisted of 45 items, on a four point Likert scale. Using a psychiatric population in the United States, five factors were found that accounted for 50.4% of the total variance. The five factors were: authoritarian control and non-psychological orientation, negative hospital orientation, external control, cause and treatment, mental illness and treatment as physical-hospital supplies regressive dependency, and let down of control for therapeutic gain-arbitrary restriction. The CPH factor scale was used to compare American and South Korean

attitudes (Kahn, Jones, Lee and Jin, 1966; Kahn, Lee, Jones and Jin, 1966-1967). A population of South Korean psychiatric patients yielded five factors which accounted for 80% of the total variance: positive acceptance of hospital, negative hospital orientation, dependence on authority for help and control, treatment and social stigma, and hereditary cause and external control. The American attitudes of authoritarian control and restriction was seen as a reflection of the emphasis on independence and rebelliousness in American culture. The South Korean attitudes of benevolence and support for an authoritarian institution was seen as a reflection of the emphasis on collectivism, dependence, and the view of mental illness as a result of external factors in South Korean culture. American views of mental illness were also seen as more complex than South Korean views of mental illness. The CPH factor scale was found to be consistent over time with similar patient populations and to adequately differentiate attitudes of patients of different cultural backgrounds (Kahn and Jones, 1969).

Karno and Edgerton (1969) studied the perceptions of mental illness in Mexican Americans and Anglo Americans. They found that Mexican Americans were likely to perceive a case description of a depressed woman as emotional or nervous illness while Anglo Americans perceived mental illness. Mexican Americans were more likily to recommend that the described woman see a physician than the Anglo Americans. Mexican Americans were more

likely to feel that a psychiatrist can be helpful, mental illness is curable and mental illness begins in childhood than Anglo Americans. Karno and Edgerton concluded that Mexican American and Anglo American perceptions and definitions of mental illness are similar. Further, they feel the underutilization of psychiatric treatment by Mexican Americans is due to a language barrier, a lack of facilities in Mexican American neighborhoods, the use of the physician and a loss of self-esteem in using psychiatric facilities.

Sechrest, Fay, Zaidi and Flores (1973) studied Pakistani, Filipino and U.S. attitudes toward mental illness using Nunnally's (1961) scale. They found that the Pakistani and Philippine attitudes were more in agreement with each other than the U.S. attitudes. Sechrest et al. found that the U.S. responses were more "modern" or "informed" than the Pakistani or Philippine responses. For example, U.S. respondents were less inclined to attribute mental disorder to sorcery or to organic processes, and less inclined to view mental patients as dangerous than were Pakistani or Filipino respondents.

The Effects of Acculturation on Attitudes Toward Mental Illness

Given that cultural groups differ in their attitudes toward mental illness, as ethnic minorities acculturate into American society, their views of mental illness will slowly converge with American views. Thus, the less acculturated an

ethnic group is, the more divergent their attitudes toward mental illness are from mainstream American society.

Edgerton and Karno (1971) studied differences in Spanish-speaking Mexican Americans and English-speaking Mexican Americans. Language usage is often used as a measure of acculturation, thus the assumption is made that those using English were more acculturated than those using Spanish. Edgerton and Karno found that those using Spanish felt depression was more serious than those using English. Those using Spanish felt delinquent children were at fault for their behavior and should be harshly punished while those using English felt the relationship between the parent and child was at fault and thus more tolerance for the delinquent child should be shown. Those using Spanish were more likely than those using English to have the attitudes that mental illness is inherited, prayer can cure mental illness and recovery from mental ilnness can best be achieved by keeping the mentally ill in the family.

Hes (1966) noted that there are differences among ethnic groups in their attitudes toward mental illness as they acculturated to the host country. Polish immigrants to Israel were compared with Yemenite and Moroccan immigrants. The Polish immigrants were more likely than the Yemenite and Moroccan immigrants to believe that: psychiatric hospitals offer treatment and are not just caretaking facilities, psychiatric patients are dangerous, and psychiatric hospitals should be avoided. The

Yemenite and Moroccan immigrants were more likely than the Polish immigrants to seek out native healers for mental illness, to attach less stigma to the mentally ill, and to expect the hospital to care for the entire family, rather than just the mentally ill individual.

The process of acculturation itself may be a factor in emotional and mental illness. DeVos (1980) identified three experiences members of ethnic minorities may go through in response to their status in the majority culture. The first is identity diffusion, an internal conflict over contrasting values with an internal sense of devaluation. The second is defensive narrowness, with the self defined by maintaining barriers against possibly enriching experiences. The third is an experience of emphasizing thoughts and sacrificing feelings in response to bitterness and being cut off from interpersonal relationships with others.

Cheung and Dobkin de Rios (1982) described some of the mental health problems facing Chinese Americans. They suggested Chinese Americans have the same rate of mental illness as other Americans, yet a greater incidence of depression, irritability, sleep disorders and other medical problems as a result of nostalgia for Chinese culture. They also suggested Chinese Americans have a greater incidence of learned helplessness and depression due to their uprooting, concomitant with role confusion and psychosocial disorientation. Chinese Americans also face

greater stress than other Americans due to discrimination, racism, underemployment, unemployment, psychological alienation and isolation, and the handicaps of language. Cheung and Dobkin de Rios suggested that Chinese Americans experience racial self-hatred and suicide due to cultural conflict. Cheung and Dobkin de Rios further suggested that Chinese Americans underutilize mental health facilities due to the attitudes toward the mentally ill, which includes shame, fear, guilt, rejection, and greater tolerance. The inability of Western therapists to work with Chinese Americans using traditional Chinese healing arts was also identified as a reason for the underutilization of mental health facilities by Chinese Americans.

Boyce and Boyce (1983) studied the relationship between family and community acculturation among Navajo boarding school students and incidence of physical illness and psychosocial problems. Navajo children from unacculturated family backgrounds were found to have a significantly higher incidence of both psychosocial problems and physical illnessess in the first year of boarding school than the Navajo children from more acculturated family backgrounds.

Padilla, Olmedo and Loya (1982) developed an acculturation scale for use with Hispanic Americans. Four factors were derived: nationality-language, father-male potency, socioeconomic status, and male potency. Hispanic Americans with a high factor score on nationality-language (indicating English language usage,

households headed by a U.S. citizen and of later generation in the U.S.) had lower scores on L and Hs and higher scores on Mf of the MMPI than Hispanic Americans with low factor scores on nationality-language. Hispanic Americans with high factor scores on socioeconomic status (fathers with higher occupational and educational levels and mothers with high educational levels) and low factor scores on male potency (rating the concept of "male" as smooth and safe) had higher scores on L and K and lower scores on Pd of the MMPI than Hispanic Americans with low factor scores on socioeconomic status and high factor scores on male potency.

Lang, Munoz, Bernal and Sorensen (1982), using the Global Acculturation Scale, which was composed of the subscores generational level, years of education in the United States, percent of life lived in the United States and language dominance/bilinguality, studied the relationship between acculturation and psychological adjustment in a San Francisco community of Latinos. They found that the Latinos who were least acculturated, with a Spanish oriented monolingualism and monoculturalism, had the poorest psychological adjustment. The Latinos with the best psychological adjustment were moderately acculturated, being bicultural and bilingual.

Therapeutic Relevance of Cultural Attitudes Toward Mental Illness

Pedersen (1982) suggested cultural barriers can lead to the underutilization of psychological services by ethnic

minorities. Pedersen pointed out a need for pluralistic therapy in which the therapist recognizes and is sensitive to the client's culturally based beliefs, values and behaviors. People from different cultures will have different expectations of the therapeutic process. The therapist must be comfortable working with clients from cultures other than their own and have knowledge of the clients cultural beliefs in order for effective change to take place.

Attitudinal factors have been shown to influece the outcome of therapy (Brady, Zeller and Reznikoff, 1959). A knowledge of ethnic beliefs and attitudes about mental illness is important when working with minority populations in the therapeutic process. Knowing how these attitudes and beliefs change with acculturation is also important for therapeutic work. Knowledge of the attitudes and expectations of clients can help therapists adopt appropriate techniques and orientations in the treatment of mental illness in ethnic and cultural minority groups.

Purpose of Study

The purpose of the present study was to develop and test a questionnaire that could discriminate attitudes toward mental illness of different cultural groups residing in the United States. Specifically, European, Hispanic and Asian cultural groups were examined.

Ethnic minority groups were expected to have significantly different attitudes toward mental illness than European ethnic groups. This study empirically tested the differences in attitudes among European, Hispanic and Asian cultural groups.

CHAPTER 2

METHOD

Phase 1

Subjects

The first phase of the study used a group of undergraduate students at a southwestern university that comprised 194 students of European ethnicity and 51 students of Hispanic ethnicity. Ethnicity was assessed by the subjects' self-report. The breakdown of the reported ethnicity of the Hispanic group was: 40 of Mexican descent, 2 of Cuban descent, 2 of South American descent, 1 of Puerto Rican descent, 1 of Mayan descent, 1 of Hispanic descent, 1 of Spanish/Mexican descent, and 3 of Mexican/Hispanic descent. The breakdown of the reported ethnicity of the European group was: 30 of mixed European descent, 29 of English descent, 25 of Jewish descent, 24 of German descent, 19 of Slavic descent, 16 of Italian descent, 16 "whites", 14 of Irish descent, 10 of Scandinavian descent, 4 of French descent, 3 of Dutch descent and 1 each of Belgian, Swiss, Scotch and Greek descent. The average age of the students of European ethnicity was 19.5. The average age of the students of Hispanic ethnicity was 20.2. There were 67 males and

127 females in the European group. In the Hispanic group, there were 18 males and 33 females. Six of the students of European ethnicity reported their parents were the first in their family to permanently settle in the United States, 26 reported their grandparents were the first to do so, and 143 reported their great grandparents or beyond were the first to do so. Nineteen students of European ethnicity reported they did not know which generation in their family were the first to settle in the United States. Two of the students of Hispanic ethnicity reported they were living in the United States temporarily, one reported being of the first generation to permanently settle in the United States, 11 reported their parents were the first to do so, nine reported their grandparents were the first to do so, 23 reported their great grandparents were the first to do so, and five reported they did not know. In their childhood homes, 187 of the ethnic European students reported speaking English, six reported speaking English and one other language, and one reported speaking a language other than English, whereas 14 of the ethnic Hispanic students reported speaking English, 26 reported speaking English and one other language, and 11 reported speaking a language other than English. In their current homes, 191 of the ethnic European students reported speaking English, two reported speaking English and one other language, and one reported speaking a language other than English, whereas 22 of the ethnic Hispanic students reported speaking English, 23 reported speaking English and one other

language and six reported speaking a language other than English. The European and some of the Hispanic students were enrolled in an introductory psychology course. The remaining Hispanic students were contacted through the mail and agreed to participate. (See Table 1 for a comparison of subject characteristics).

Table 1

Subject Characteristics

Breakdown of Mean Age

	Phase 1	Phase 2	Exploratory
European	19.5	19.3	19.4
Hispanic	20.2	19.7	19.9
Asian			25.0

Breakdown of Gender

	Phase 1		Phase 2		Exploratory	
	Male	Female	Male	Female	Male	Female
European	67	127	61	133	128	260
Hispanic	18	33	15	35	51	68
Asian					44	22

Table 1 Continued

Subject Characteristics

Breakdown of Ethnicity

	Phase 1	Phase 2	Exploratory
Mixed European	30	29	59
English	29	29	58
Jewish	25	26	51
German	24	24	48
Slavic	19	19	38
Italian	16	17	33
"White"	16	16	32
Irish	14	15	29
Scandinavian	10	10	20
French	4	4	8
Dutch	3	2	5
Belgian	1	0	1
Swiss	1	0	1
Scotch	1	0	1
Greek	1	1	2
Canadian	0	1	1
Portuguese	0	1	1
Mexican	40	39	79
Cuban	2	2	4
South American	2	2	4
Puerto Rican	1	1	2
Mayan	1	0	1
Hispanic	1	1	2
Spanish/Mexican	1	1	2
Mexican/Hispanic	3	4	7
Chinese			52
Malaysian			5
Filipino			4
Vietnamese			2
Japanese			1
Korean			1
Indonesian			1

Table 1 Continued

Subject Characteristics

Breakdown of First Members of Family to Settle in the U.S.

	Great Grandparent	Grand-parent	Parent	Self	Temp-orary	Don't Know
European						
Phase 1	143	26	6	0	0	19
Phase 2	137	34	7	0	2	14
Hispanic						
Phase 1	23	9	11	1	2	5
Phase 2	21	12	13	1	1	2
Asian	4	3	8	7	39	5

Breakdown of Language Usage in the Childhood Home

	English	A Language Other Than English	English and Some Other Language
European			
Phase 1	187	1	6
Phase 2	183	1	10
Hispanic			
Phase 1	14	11	26
Phase 2	15	11	24
Asian	4	52	10

Table 1 Continued

Subject Characteristics

Breakdown of Language Usage in Current Home

	English	A Language Other Than English	English and Some Other Language
European			
Phase 1	191	1	2
Phase 2	187	0	7
Hispanic			
Phase 1	22	6	23
Phase 2	25	3	22
Asian	10	36	20

Instrumentation

In the present study, a 150 item scale was administered to the subjects. The items of this scale came from three sources. Sixty items of the 150 item scale came from Nunnally's (1961) scale which was used to measure attitudes toward mental illness, despite recent criticisms. The scale has been used extensively in past research, and has previously exhibited adequate reliability. The second source of items was the CPH factor scale (Kahn, Jones, MacDonald, Conners & Burchard, 1963). The 22 items taken from the CPH factor scale dealt with such themes as mental hospitalization and psychiatric care. The remaining 68 items were developed for this study to examine attitudes toward mental illness not necessarily covered in the other two groups of items, for the purpose of better differentiation between cultural groups. The

themes of some of these original items involved the heritability of mental illness, supernatural or religious causes of mental illness, treatment of mental illness, the role of the family in mental illness, stigma of the mentally ill, and symptoms that may or may not require psychological treatment.

Items on the scale were of the following kind: "Will power alone will not cure mental disorders"; "Mental disorder is usually brought on by physical causes"; "There is not much that can be done for a person who develops a mental disorder"; "Once you have been in a mental hospital people treat you like you are peculiar or different"; "A mental hospital is the best place to let go your emotions"; "Bad dreams and nightmares can cause mental disorders"; "Spirits and ghosts can not cause people to have emotional problems"; and "It is important to seek treatment for mental disorders as soon as possible." Subjects indicated agreement with each statement on a four point scale, with 1 being strongly disagree, 2 being slightly disagree, 3 being slightly agree and 4 being strongly agree. (See Appendix A).

Procedure

All subjects voluntarily consented to participate. All subjects were administered the questionnaire, consisting of 150 items. An item analysis was performed to determine which items significantly discriminated the Europeans from the Hispanics. The t test was used for this purpose. Those items from the initial

pool of items which differentiated the groups at a probability level of .20 or less were selected for a new scale to be cross-validated on a new sample.

Phase 2

Phase 2 of the study concerned the cross-validation of the new scale.

Subjects

The subjects in phase 2 were obtained in the same way as subjects in phase 1. The phase 2 group was comprised of 194 subjects of European ethnicity and 50 subjects of Hispanic ethnicity. Ethnicity was assessed by the subjects' self-report. The breakdown of the reported ethnicity of the Hispanic group was: 39 of Mexican descent, 4 of Mexican/Hispanic descent, 2 of Cuban descent, 2 of South American descent, 1 of Puerto Rican descent, 1 of Spanish/Mexican descent, and 1 of Hispanic descent. The breakdown of the reported ethnicity of the European group was: 29 of mixed European descent, 29 of English descent, 26 of Jewish descent, 24 of German descent, 19 of Slavic descent, 17 of Italian descent, 16 "whites", 15 of Irish descent, 10 of Scandinavian descent, 4 of French descent, 2 of Dutch descent, and 1 each of Canadian, Greek and Portuguese descent. The average age of the students of European ethnicity was 19.3. The average age of the students of Hispanic ethnicity was 19.7. There were 61 males and

133 females in the European group. In the Hispanic group, there were 15 males and 35 females. Two of the students of European ethnicity reported they were living in the United States temporarily, seven reported their parents were the first in their family to permanently settle in the United States, 34 reported their grandparents were the first to do so, 137 reported their great grandparents or beyond were the first to do so, and 14 reported they did not know. One student of Hispanic ethnicity was living in the United States temporarily, one reported being of the first generation to permanently settle in the United States, 13 reported their parents were the first to do so, 12 reported their grandparents were the first to do so, 21 reported their great grandparents or beyond were the first to do so, and two reported they did not know. In their childhood homes, 183 of the ethnic European students reported speaking English, ten reported speaking English and one other language, and one reported speaking a language other than English, whereas 15 of the ethnic Hispanic students reported speaking English, 24 reported speaking English and one other language, and 11 reported speaking a language other than English. In their current homes, 187 of the ethnic European students reported speaking English and seven reported speaking English and one other language, whereas 25 of the ethnic Hispanic

students reported speaking English, 22 reported speaking English and one other language, and three reported speaking a language other than English.

Instrumentation

The instrumentation in phase 2 was identical to the instrumentation in phase 1.

Procedure

The subjects were administered all 150 items. The items that discriminated the two groups at the .20 level or less were compared with the items that discriminated the two groups in phase 1. The items that discriminated the two groups in both phases constituted the new scale. (See Table 2).

Exploratory Study

An additional exploratory study was carried out to examine Asian attitudes toward mental illness. Only some hypotheses can be drawn from this exploratory study for further research because not enough Asian subjects were obtained to perform a cross-validation.

Subjects

The exploratory phase of the study examined European, Hispanic and Asian attitudes toward mental illness. Ethnicity was assessed by the subjects' self-report. The subjects from phase 1

and phase 2 were grouped together to form a group of 388 European subjects and a group of 101 Hispanic subjects.

An additional group of 66 Asian students participated in the study. The breakdown of the reported ethnicity of the Asian group was: 52 of Chinese descent, 5 of Malaysian descent, 4 of Filipino descent, 2 of Vietnamese descent, and 1 each of Japanese, Korean and Indonesian descent. The average age of the students of Asian ethnicity was 25.0. There were 44 males and 22 females in the Asian group. Thirty-nine of the students of Asian ethnicity reported they were living in the United States temporarily, seven reported they were the first generation of their family to permanently settle in the United States, eight reported their parents were the first to do so, three reported their grandparents were the first to do so, four reported their great grandparents or beyond were the first to do so, and five reported they did not know. In their childhood homes, four of the ethnic Asian students reported speaking English, ten reported speaking English and one other language, and 52 reported speaking a language other than English. In their current homes, ten of the ethnic Asian students reported speaking English, 20 reported speaking English and one other language, and 36 reported speaking a language other than English. Some of these students were enrolled in an introductory psychology course, and some of them belonged to three separate Chinese student organizations. The presidents of these organizations were contacted. Two of the presidents agreed to

allow the researcher to attend a meeting of the organization and talk to the students to ask their cooperation. The third president allowed the researcher to have access to the organization's mailing list and ask the students' cooperation by mail. All the Asian students attended the same university as the European and Hispanic students.

Instrumentation

The instrumentation in phase 3 was identical to the instrumentation in phase 1 and phase 2.

Procedure

The Asian subjects were administered the initial 150 items scale. An item analysis was performed to determine which items significantly discriminatcd the Asians from the Europeans and which items discriminated the Asians from the Hispanics. A one-way analysis of variance was used for this purpose. Those items from the initial pool of items which differentiated the groups at a probability level of .001 or less constituted a new scale. (See Table 4). These items were not cross-validated on a new sample.

CHAPTER 3

RESULTS

In phase 1 of the study, 52 items out of 150 discriminated at the .20 level or less. In phase 2 of the study, 43 items out of 150 discriminated at the .20 level or less. Of these 43 items, 15 were found to have been among the 52 items which discriminated the Europeans and Hispanics in phase 1. These 15 items constitute the new scale and are given in Table 2.

Table 2

Items that distinguished Europeans from Hispanics at $p < .20$ on cross-validation sample

Item	Group	Mean	t value	p
Hopefulness				
23. Mental disorder is one of the most damaging illnesses that a person can have.	European	2.89	1.42	.159
	Hispanic	2.64		
33. Mental patients usually make a good adjustment to society when they are released.	European	2.39	-2.68	.008
	Hispanic	2.70		
100. A mentally disordered person needs someone to look after them at all times.	European	2.12	-1.40	.164
	Hispanic	2.30		

Table 2 continued

Items that distinguished Europeans from Hispanics at $p < .20$ on cross-validation sample

Item	Group	Mean	t value	p
103.People who do not seek help for mental problems lose all hope of ever getting better.	European Hispanic	2.03 2.40	-2.34	.022
138.A person who has overcome a mental disorder is always close to another breakdown.	European Hispanic	1.98 2.30	-2.61	.010
Trust				
68.A person is more likely to be hurt than helped in a mental hospital.	European Hispanic	1.55 1.76	-1.79	.075
105.Most people get better after seeking treatment for mental disorders.	European Hispanic	2.90 3.08	-1.48	.142
110.People with mental disorders need to place total trust in their therapist to get better.	European Hispanic	2.87 3.16	-2.13	.034
Biological Aspects				
59.Physical rest will not prevent a mental disorder.	European Hispanic	2.68 2.50	1.33	.184
61.Mental illness is something that runs in families.	European Hispanic	2.43 2.10	2.23	.026
Childhood Origins				
45.Good emotional habits can be taught to children in school as spelling can.	European Hispanic	2.60 2.80	-1.31	.190
84.If a woman is not careful when pregnant, her children may have emotional problems later in life.	European Hispanic	1.94 2.18	-1.53	.129

Table 2 continued

Items that distinguished Europeans from Hispanics at $p < .20$ on cross-validation sample

Item	Group	Mean	t value	p
Finances				
32. Helping the mentally ill person with his financial and social problems often improves his condition.	European	2.68	-1.95	.053
	Hispanic	2.92		
144. People who steal need psychological treatment.	European	3.13	1.83	.069
	Hispanic	2.88		
Sex Differences				
7. Women have no more emotional problems than men do.	European	2.77	1.81	.072
	Hispanic	2.48		

These items were considered to be measuring reliable differences between the groups, as they twice differentiated Europeans and Hispanics on separate samples. The 15 item scale was designated the Ethnic Mental Illness Scale (EMI Scale). Of the 15 items, six were from Nunnally's scale, two were from the CPH factor scale, and the remaining seven were devised for this study.

Europeans and Hispanics were not significantly different (i.e. the probability of difference was greater than .20) on 75 of the items in both phase 1 and phase 2 of the study. These 75 items are given in Table 3.

Table 3

Items which did not differentiate Europeans
from Hispanics on cross-validation sample

Item	Group	Mean	t value	p
Cognitive Views				
2.People who keep themselves occupied with pleasant thoughts seldom become mentally ill.	European Hispanic	2.35 2.52	-1.17	.244
6.Will power alone will not cure mental disorders.	European Hispanic	3.12 3.10	0.18	.854
11.Mental illness can usually be helped by a vacation or change of scene.	European Hispanic	2.25 2.30	-0.30	.762
13.The main job of the psychiatrist is to recommend hobbies and other ways for the mental patient to occupy his mind.	European Hispanic	2.07 2.04	0.22	.824
15.Psychiatrists try to show the mental patient where his ideas are incorrect.	European Hispanic	2.33 2.32	0.10	.920
21.The best way to mental health is by avoiding morbid thoughts.	European Hispanic	2.09 2.16	-0.47	.641
28.If a person concentrates on happy memories, he will not be bothered by unpleasant things in the present.	European Hispanic	1.86 1.86	0.05	.964
42.A person can avoid worry by keeping busy.	European Hispanic	2.57 2.52	0.35	.724
49.A person cannot rid himself of unpleasant memories by trying hard to forget them.	European Hispanic	2.98 3.06	-0.45	.653
85.Bad dreams and nightmares can cause mental disorders.	European Hispanic	2.45 2.38	0.56	.578

Table 3 continued

Items which did not differentiate Europeans from Hispanics on cross-validation sample

Item	Group	Mean	t value	p
96.There are some people who will never be mentally disordered because of their outlook on life.	European Hispanic	2.99 2.92	0.50	.617
131.Thinking bad or weird thoughts can cause someone to become physically ill.	European Hispanic	1.83 1.96	-0.87	.385
137.People who are very talented think in strange or bizarre ways.	European Hispanic	2.32 2.30	0.17	.866
Emotions				
10.Psychiatrists try to teach mental patients to hold in their strong emotions.	European Hispanic	1.57 1.79	-1.28	.204
77.A mentally well person is one that keeps his feelings and his emotions to himself.	European Hispanic	1.41 1.30	1.13	.261
83.A mental hospital is the best place to let go your emotions.	European Hispanic	2.53 2.66	-0.90	.368
99.Giving up in the face of problems can lead to mental disorders.	European Hispanic	2.58 2.64	-0.41	.680
132.The way other people treat us affects our emotions.	European Hispanic	3.62 3.58	0.47	.640
133.The way I treat people can have a large affect on their emotions.	European Hispanic	3.54 3.62	-0.73	.466
Biological Aspects				
8.X-rays of the head will not tell whether a person is likely to become insane.	European Hispanic	3.18 3.30	-0.78	.435

Table 3 continued

Items which did not differentiate Europeans
from Hispanics on cross-validation sample

Item	Group	Mean	t value	p
25.Nervous breakdowns seldom have a physical origin.	European	2.03	-1.05	.297
	Hispanic	2.16		
36.Almost any disease that attacks the nervous system is likely to bring on insanity.	European	1.88	0.16	.873
	Hispanic	1.86		
43.A poor diet often leads to feeble-mindedness.	European	2.54	-0.10	.924
	Hispanic	2.56		
126.Mental disorders are really just something going wrong with your body that makes you act differently.	European	1.92	-0.09	.925
	Hispanic	1.94		
145.Menopause can make a woman become mentally disordered.	European	2.38	-0.13	.901
	Hispanic	2.40		
Hopefulness				
3.Few people who enter mental hospitals ever leave.	European	1.75	-0.89	.373
	Hispanic	1.88		
22.There is not much that can be done for a person who develops a mental disorder.	European	1.45	-0.57	.572
	Hispanic	1.52		
53.Most of the time psychiatrists have difficulty in telling whether or not a patient's mental disorder is curable.	European	2.32	-0.08	.937
	Hispanic	2.34		
76.Mental hospitals may help some patients but quite a few are discharged without real improvement.	European	2.52	0.68	.497
	Hispanic	2.44		

Table 3 continued

Items which did not differentiate Europeans from Hispanics on cross-validation sample

Item	Group	Mean	t value	p
Social Support				
5.People cannot maintain good mental health without the support of strong persons in their environment.	European Hispanic	2.69 2.76	-0.43	.671
29.The mentally ill have not received enough guidance from the important people in their lives.	European Hispanic	2.39 2.44	-0.31	.754
70.A mentally well person is one who is liked and appreciated by everybody.	European Hispanic	1.93 1.90	0.26	.791
82.Mental illness is due to past experiences people have had with other people.	European Hispanic	2.76 2.72	0.35	.728
91.A person's family may sometimes cause someone to become mentally disordered.	European Hispanic	2.95 2.84	0.85	.394
93.Bad marriages can cause the husband or wife to become mentally disordered.	European Hispanic	3.08 3.00	0.63	.531
95.Having a lot of friends can prevent someone from becoming mentally disordered.	European Hispanic	2.31 2.38	-0.49	.628
107.Treatment for mental disorders should include the whole family, not just one person.	European Hispanic	3.23 3.18	0.39	.696
109.People can become mentally disordered because they don't get along well with their families.	European Hispanic	2.94 2.84	1.00	.316

Table 3 continued

Items which did not differentiate Europeans from Hispanics on cross-validation sample

Item	Group	Mean	t value	p
Severity				
9.Emotional problems do little damage to the individual.	European Hispanic	1.30 1.24	0.58	.560
17.Mental health is one of the most important national problems.	European Hispanic	2.84 2.72	0.86	.388
31.The seriousness of the mental health problem in this country has been exaggerated.	European Hispanic	1.91 1.84	0.59	.558
54.Children usually do not forget about frightening experiences in a short time.	European Hispanic	3.31 3.44	-0.86	.391
102.It is important to seek treatment for mental disorders as soon as possible.	European Hispanic	3.41 3.40	0.15	.878
Symptoms				
26.Most of the people in mental hospitals speak in words that can be understood.	European Hispanic	3.11 3.20	-0.71	.476
46.The eyes of the insane are glassy.	European Hispanic	1.53 1.42	0.98	.327
52.People who are likely to have a nervous breakdown pay little attention to their personal appearance.	European Hispanic	2.28 2.14	1.11	.269
118.Mentally disordered people do not really act any different from other people.	European Hispanic	2.04 2.16	-0.98	.327

Table 3 continued

Items which did not differentiate Europeans from Hispanics on cross-validation sample

Item	Group	Mean	t value	p
140.People should seek psychological treatment if they hear voices that aren't really there.	European	3.01	0.92	.359
	Hispanic	2.88		
141.People do not need psychological treatment if they are sad and tired all the time.	European	1.77	-0.51	.613
	Hispanic	1.84		
142.People who feel like they are going to faint if they leave their house do not need psychological treatment.	European	1.57	-0.82	.412
	Hispanic	1.68		
143.People should seek psychological treatment if they drink too much alcohol.	European	3.31	0.61	.544
	Hispanic	3.24		
148.People don't need psychological treatment if they are withdrawn and have no friends.	European	1.72	-0.78	.435
	Hispanic	1.82		
150.People who are tense all the time and do not know how to relax should seek psychological treatment.	European	2.88	0.98	.328
	Hispanic	2.76		
Stigma				
64.Once you have been in a mental hospital people treat you like you are peculiar or different.	European	2.74	-0.82	.412
	Hispanic	2.86		
65.It's always possible that one might be hurt by other patients in a mental hospital.	European	2.90	0.06	.954
	Hispanic	2.90		
78.Once you've been in a mental hospital people won't ever treat you the same as they did before your mental illness.	European	2.44	0.45	.653
	Hispanic	2.38		

Table 3 continued

Items which did not differentiate Europeans from Hispanics on cross-validation sample

Item	Group	Mean	t value	p
120.Mentally disordered people can work side by side with other people.	European Hispanic	3.18 3.22	-0.31	.757
121.I would feel uncomfortable if people knew someone in my family was mentally disodered.	European Hispanic	2.35 2.22	0.90	.367
Religious Ideas				
89.People become mentally disordered because they do bad things to other people.	European Hispanic	1.38 1.50	-0.98	.327
90.Mental disorders are caused by possession by the devil.	European Hispanic	1.18 1.24	-0.57	.566
101.One's clergyman can sometimes be more helpful than a psychologist if one is in emotional distress.	European Hispanic	2.70 2.78	-0.59	.559
130.The best cure for mental disorders is prayer.	European Hispanic	1.87 1.92	-0.34	.736
Miscellaneous				
4.Older people have fewer emotional problems than younger people.	European Hispanic	1.81 1.82	0.00	.997
12.Disappointments affect children as much as they do adults.	European Hispanic	3.28 3.22	0.49	.622
19.It is easier for women to get over emotional problems than it is for men.	European Hispanic	1.79 1.86	-0.47	.642
20.A change of climate seldom helps an emotional disorder.	European Hispanic	2.48 2.42	0.56	.573

Table 3 continued

Items which did not differentiate Europeans from Hispanics on cross-validation sample

Items	Group	Mean	t value	p
41.People who have little sexual desire are more likely to have a "nervous breakdown" than are other people.	European Hispanic	1.79 1.74	0.44	.662
44.Emotionally upset persons are often found in important positions in business.	European Hispanic	2.63 2.48	1.07	.286
67.The mental hospital is a place to get away from your problems.	European Hispanic	1.59 1.52	0.59	.557
69.Most psychiatrists are too young to know what they are doing.	European Hispanic	1.41 1.48	-0.62	.534
75.A person is deprived of most of his rights while in a mental hospital.	European Hispanic	2.34 2.52	-1.28	.202
92.Too much stress and pressure at work can cause a person to become mentally disordered.	European Hispanic	3.23 3.24	-0.07	.944
108.Many different kinds of treatment should be used to help a mentally disordered person.	European Hispanic	3.12 3.08	0.39	.699
125.If a person's surroundings are bad, then that person cannot help but be mentally disordered.	European Hispanic	1.78 1.96	-1.16	.251
135.Every person is unique and different from every other person.	European Hispanic	3.76 3.82	-0.69	.493

These items were considered to represent attitudes toward mental illness the two groups did not differ on both initially and on replication. Of the 75 items, 32 were from Nunnally's scale, 10 were from the CPH factor scale, and the remaining 33 were devised for this study.

In the exploratory phase of the study, the comparison of the European, Hispanic and Asian subjects, 36 items discriminated at the .001 level or less. Twenty-seven of the items discriminated the Asians from the Europeans, and nine of the items discriminated the Asians from the Hispanics. These 36 items are given in Table 4.

Table 4

Items that differentiated Asians from Europeans and Hispanics at the $p < .001$ level

Item	Group	Mean	F	p
Cognitive Views				
2.People who keep themselves occupied with pleasant thoughts seldom become mentally ill.	European Asian	2.29 3.09	21.22	.001
21.The best way to mental health is by avoiding morbid thoughts.	European Asian	2.05 2.78	21.22	.001
28.If a person concentrates on happy memories, he will not be bothered by unpleasant things in the present.	European Asian	1.90 2.78	27.84	.001

Table 4 continued

Items that differentiated Asians from Europeans and Hispanics at the $p < .001$ level

Item	Group	Mean	F	p
55.Books on "peace of mind" prevent many people from developing nervous breakdowns.	European Asian	2.18 2.60	8.64	.001
131.Thinking bad or weird thoughts can cause someone to become physically ill.	European Asian	1.84 2.45	12.93	.001
Emotions				
10.Psychiatrists try to teach mental patients to hold in their strong emotions.	European Asian	1.58 2.43	26.74	.001
38.People who become mentally ill have little will power.	European Asian	1.93 2.51	13.38	.001
77.A mentally well person is one that keeps his feelings and his emotions to himself.	European Asian	1.43 2.24	36.50	.001
Stigma				
47.When a person is recovering from a mental illness, it is best not to discuss the treatment that he has had.	Hispanic Asian	2.03 2.69	14.47	.001
78.Once you've been in a mental hospital people won't ever treat you the same as they did before your mental illness.	European Asian	2.41 2.96	11.11	.001
80.Once having been mentally ill you should be excused for many things you do.	Hispanic Asian	1.35 2.07	25.50	.001
119.It is all right to spend time with mentally disordered people.	European Asian	3.53 3.12	10.41	.001

Table 4 continued

Items that differentiated Asians from Europeans and Hispanics at the $p < .001$

Item	Group	Mean	F	p
139.People with mental disorders should not be allowed to have children.	European	1.83	8.26	.001
	Asian	2.31		
Social Support				
70.A mentally well person is one who is liked and appreciated by everybody.	European	1.89	9.27	.001
	Asian	2.42		
95.Having a lot of friends can prevent someone from becoming mentally disordered.	European	2.25	10.20	.001
	Asian	2.78		
113.If people treated each other with care and respect there would not be mental disorders.	European	2.07	24.75	.001
	Asian	2.86		
114.Children become emotionally disturbed if they are treated unkindly.	European	2.97	9.95	.001
	Asian	3.33		
124.The people best suited to help a mentally disordered person is that person's family.	European	2.35	17.80	.001
	Asian	3.03		
Symptoms				
14.The insane laugh more than normal people.	European	1.64	15.64	.001
	Asian	2.24		
37.You can tell a person who is mentally ill from his appearance.	Hispanic	1.48	15.05	.001
	Asian	2.07		
46.The eyes of the insane are glassy.	Hispanic	1.44	34.25	.001
	Asian	2.30		

Table 4 continued

Items that differentiated Asians from Europeans and Hispanics at the $p < .001$ level

Item	Group	Mean	F	p
142.People who feel like they are going to faint if they leave their house do not need psychological treatment.	European Asian	1.64 2.09	7.68	.001
143.People should seek psychological treatment if they drink too much alcohol.	European Asian	3.24 2.75	8.13	.001
144.People who steal need psychological treatment.	European Asian	3.12 2.66	9.87	.001
Perceptions of Psychiatrists				
53.Most of the time psychiatrists have difficulty in telling whether or not a patient's mental disorder is curable.	Hispanic Asian	2.28 3.04	21.86	.001
69.Most psychiatrists are too young to know what they are doing.	European Asian	1.39 1.95	17.03	.001
116.Psychologists are able to read minds.	Hispanic Asian	1.15 1.86	24.31	.001
Severity				
31.The seriousness of the mental health problem in this country has been exaggerated.	Hispanic Asian	1.87 2.36	12.67	.001
100.A mentally disordered person needs someone to look after them at all times.	European Asian	2.11 2.53	9.45	.001
115.If a mentally disordered person is able to hold a job, then there is really nothing wrong with him or her.	European Asian	1.55 2.16	20.90	.001

Table 4 continued

Items that differentiated Asians from Europeans and Hispanics at the $p < .001$ level

Items	Group	Mean	F	p
Vacation as Cure				
11.Mental illness can usually be helped by a vacation or change of scene.	European	2.27	19.79	.001
	Asian	3.03		
74.The mental hospital is like a vacation at a resort.	European	1.27	20.25	.001
	Asian	1.80		
Miscellaneous				
7.Women have no more emotional problems than men do.	European	2.77	18.00	.001
	Asian	1.96		
22.There is not much that can be done for a person who develops a mental disorder.	Hispanic	1.42	8.40	.001
	Asian	1.84		
36.Almost any disease that attacks the nervous system is likely to bring on insanity.	Hispanic	1.75	8.83	.001
	Asian	2.22		
127.Mental health is to be in balance with nature.	European	2.42	10.42	.001
	Asian	2.93		

These differences may not hold up under cross-validation. Not enough subjects of Asian ethnicity were obtained for cross-validation. The results of this study are for exploratory purposes only. Of the 36 items, 16 were from Nunnally's scale, six were from the CPH factor scale, and 14 were devised for this study.

Europeans, Hispanics and Asians were not statistically different (i.e. the probability of difference was greater than .50) on 21 of the items. These 21 items are given in Table 5.

Table 5

Items which did not differentiate Asians from Europeans and Hispanics

Item	Group	Mean	F	p
Biological Aspects				
8.X-rays of the head will not tell whether a person is likely to become insane.	European	3.20	.35	.704
	Hispanic	3.27		
	Asian	3.28		
18.Mental disorder is usually brought on by physical causes.	European	2.18	.02	.973
	Hispanic	2.16		
	Asian	2.19		
73.A mental hospital is a place where patients can benefit mainly by receiving three well-balanced meals a day.	European	1.63	.26	.770
	Hispanic	1.69		
	Asian	1.68		
128.If you can find what's wrong with the body, you can cure mental disorders.	European	1.96	.21	.804
	Hispanic	2.01		
	Asian	1.96		
145.Menopause can make a woman become mentally disordered.	European	2.36	.52	.594
	Hispanic	2.46		
	Asian	2.34		
Cognitive Views				
15.Psychiatrists try to show the mental patient where his ideas are incorrect.	European	2.42	.09	.913
	Hispanic	2.46		
	Asian	2.40		
49.A person cannot rid himself of unpleasant memories by trying hard to forget them.	European	3.05	.12	.880
	Hispanic	3.00		
	Asian	3.04		

Table 5 continued

Items which did not differentiate Asians from Europeans and Hispanics

Item	Group	Mean	F	p
85.Bad dreams and nightmares can cause mental disorders.	European	2.39	.37	.685
	Hispanic	2.42		
	Asian	2.30		
99.Giving up in the face of problems can lead to mental disorders.	European	2.56	.57	.560
	Hispanic	2.63		
	Asian	2.50		
Family Support				
5.People cannot maintain good mental health without the support of strong persons in their environment.	European	2.65	.51	.598
	Hispanic	2.76		
	Asian	2.63		
91.A person's family may sometimes cause someone to become mentally disordered.	European	2.92	.46	.630
	Hispanic	2.91		
	Asian	3.03		
107.Treatment for mental disorders should include the whole family, not just one person.	European	3.19	.33	.716
	Hispanic	3.24		
	Asian	3.13		
109.People can become mentally disordered because they don't get along well with their families.	European	2.88	.16	.847
	Hispanic	2.85		
	Asian	2.83		
Emotions				
40.Most mental disturbances in adults can be traced to emotional experiences in childhood.	European	3.10	.61	.540
	Hispanic	3.16		
	Asian	3.18		
51.Most suicides occur because of rejection in love.	European	2.62	.26	.764
	Hispanic	2.59		
	Asian	2.53		
132.The way other people treat us affects our emotions.	European	3.60	.13	.872
	Hispanic	3.63		
	Asian	3.63		

Table 5 continued

Items which did not differentiate Asians
from Europeans and Hispanics

Item	Group	Mean	F	p
Symptoms				
140.People should seek psychological treatment if they hear voices that aren't really there.	European	2.97	.08	.922
	Hispanic	2.96		
	Asian	2.92		
148.People don't need psychological treatment if they are withdrawn and have no friends.	European	1.72	.53	.585
	Hispanic	1.81		
	Asian	1.78		
149.People who get divorced more than twice should seek psychological treatment.	European	2.10	.13	.874
	Hispanic	2.11		
	Asian	2.16		
Miscellaneous				
65.It's always possible that one might be hurt by other patients in a mental hospital.	European	2.90	.55	.573
	Hispanic	2.87		
	Asian	3.00		
134.Who we are is in part determined by the people around us.	European	3.21	.06	.935
	Hispanic	3.23		
	Asian	3.19		

Due to the exploratory nature of this study, these items were considered, very tentatively so, to represent attitudes toward mental illness on which the three groups did not differ. Of the 21 items, seven were from Nunnally's scale, two were from the CPH factor scale, and 12 were devised for this study.

CHAPTER 4

DISCUSSION

In the development of the scale to differentiate the three groups, statistically significant differences were found, although the differences between the means were relatively small, averaging at .25 for the differences between the Europeans and the Hispanics, and averaging at .60 for the differences between the Asians and the Europeans and Hispanics. Such small differences call into question whether these differences are clinically significant differences. There may in fact be no realistically meaningful differences between the European, Hispanic and Asian subjects, and this should be kept in mind when considering the following discussion.

Items That Differentiated Hispanics and Europeans

The questionnaire developed and cross-validated in this study was based on existing measures of attitudes toward mental illness and original items that were expected to differentiate

ethnic groups. The EMI Scale appears able to measure differences between ethnic European and Hispanic atttitudes toward mental illness.

Hopefulness

Five of the items involved a theme of hopefulness. These tendencies suggest that while Hispanics are more hopeful in general about mental illness than Europeans, Hispanics are more cautious of relapses of mental illness. These tendencies may stem from a lesser financial capability to cope with physical illness in the Hispanic community, thus mental illness is not viewed as damaging in comparison. Thus, those with past problems of mental illness are expected to adjust to life once the problems are over, because the problems were not seen as very serious in the first place. Doubt remains about the recurrence of mental problems in the Hispanic community, possibly as a result of less knowledge about mental illness, or because recurrence of problems is frequent among Hispanics.

Trust in the Mental Health Care Giving System

Three of the items involved a theme of trust in the mental health care giving system. These tendencies suggest that Hispanics are more trusting than Europeans of treatment for mental illness and the mental health professional, possibly due to a greater respect for authority in Hispanic culture. However, if treatment

takes place in a mental hospital, Hispanics are less trusting than Europeans. This tendency may suggest a dislike amongst Hispanics to be uprooted and isolated from their community, where natural family and neighborhood support systems exist.

Biological Aspects of Mental Illness

Two of the items involve a theme of biological aspects of mental illness. These tendencies suggest Hispanics believe more strongly than Europeans in a link between physical and mental well being, and reject a genetic explanation for mental illness more strongly than Europeans. Possibly, Hispanics reject a genetic explanation because of a want to avoid blame for mental illness within their family. They may accept a physical and mental link because they have a more holistic attitude toward health, or because they do not give as much credence to psychological thought processes as the sole contributor to mental illness as do Europeans.

Childhood Origins

Two items involved a theme of childhood origins of mental illness. These tendencies suggest that Hispanics may believe mental illness can originate in childhood, and possibly spend more time teaching children about emotions than Europeans.

Finances

Two items involved a theme of finances. These tendencies suggest Hispanics possibly are more attuned to financial difficulties, and feel financial help can ameliorate problems. Hispanics also possibly understand motivations for theft better than Europeans, and thus don't view theft as mental illness. This suggests Hispanics expect legal action to be taken for thieves rather than intervention in the mental health system, and that Hispanics possibly have a greater moral sanction against theft than Europeans.

Sex Differences

The last item dealt with sex differences of mental illness. Hispanics possibly view men as stronger in constitution than women, potentially as a result of the cultural notion of machismo. This finding suggests Hispanic women also endorse the notion of machismo, or that Hispanic women view themselves as weak, as two-thirds of the Hispanic sample were women.

Items on which Hispanic and European Attitudes Did Not Differ

Hispanics and Europeans were found to not differ in regard to some of their attitudes toward mental illness. The 75 items on which Hispanics and Europeans did not differ in their attitudes toward mental illness were categorized on an a priori basis in

terms of the context of the items. Sixty-two of the items seemed to group into nine categories, with 13 additional miscellaneous items.

Cognitive Views and Mental Illness

The first category included 13 items and involved the theme that thoughts and mental illness are unrelated. In general, Hispanics and Europeans did not differ in their beliefs that changing one's thoughts can not stop one from being mentally ill and that one's thoughts do not cause mental illness. This suggests that people are unaware of the importance that cognitions can have in contributing to mental illness.

Emotions and Mental Illness

The second category consisted of six items and involved the theme of emotions. These items suggest that people are also unaware of how affect can contribute to mental illness.

Biological Aspects of Mental Illness

The third category consisted of six items and involved the theme of the connection between physical and mental phenomena. This theme suggests that in most circumstances, people believe physical and psychological experiences are distinct, and they may be overlooking how mind and body can interact in healthy and unhealthy ways.

Hopefulness

The fourth category consisted of four items and involved the theme of hopefulness. This theme suggests people have a positive outlook on the course and cure of mental illness, and that if treated and attended to, mental illness can be alleviated.

Social Support

The fifth category consisted of nine items and involved a theme of social support. This theme suggests that people are attuned to the importance of family support in preventing mental illness, and that they may be overlooking other sources of social support. They may not, however, find non-family sources of support beneficial.

Severity

Severity of mental illness was the theme of the sixth category, which consisted of five items. These items suggest that people believe mental illness needs to be attended to on the individual level, but that national efforts should go to other endeavors than curing or preventing mental illness.

Symptoms

The seventh category consisted of ten items and involved a theme of symptoms of mental illness. This theme suggests that both Hispanics and Europeans are attuned to mental health problems that may need to be attended to by mental health professionals. These

findings also suggest people understand that mental illness cannot always be detected from easy observation. Because college students in general are regularly under stress and thus view stress as normal, the subjects may have responded that problems of tension and stress do not need psychological treatment.

Stigma

The eigth category consisted of five items and involved a theme of stigma. The subjects' nonstigmatizing attitudes may be a result of the university sample. Students educated in psychology may indeed have less stigmatizing attitudes toward mental illness, or they may better understand the socially desirable responses to such items.

Religious Ideas

The ninth category consisted of four items and involved a theme of religious ideation. The subjects' nonreligious attitudes may be explained by their attendance at a university. A person with an American college education may be less likely to view mental illness as due to supernatural or religious causes, and more prone to take a scientific view.

Miscellaneous

There were an additional 13 items of the 75 items on which Hispanics and Europeans did not differ that did not group into categories.

Items That Differentiate Asians from Europeans and Hispanics

Asians appear to have some attitudes about mental illness that differ from the attitudes of both Europeans and Hispanics. The items that differentiated the Asians from the other two groups seemed to cluster into eight categories, with four miscellaneous items. It should be recognized that the results of the exploratory study were not cross-validated, and thus the discussion of the results should be viewed as preliminary to further work with an Asian cross-validation sample.

Cognitive Views and Mental Illness

Five of the items involved a theme of cognitions. In general, Asians were more accepting of a link between thoughts and illness. Asians were more likely than Europeans to believe bad thoughts can cause mental illness and good thoughts can prevent mental illness. This tendency may suggest Asians are more contemplative and better understand the link between cognitions, affect and behavior.

Emotions and Mental Illness

Three of the items involved a theme of emotions. In general, Asians seemed to equate mental health with control over one's emotions. Asians may view mental illness as letting one's emotions get out of control, while Europeans and Hispanics view

mental illness as bottling up one's emotions and not expressing them.

Stigma

Five of the items involved a theme of stigma, or how the mentally ill should be treated. In general, Asians were more cautious about interacting with mentally ill people, yet were more forgiving of their behavior. Their caution may possibly be a result of fear of the mentally ill, a greater potential for dangerous behavior in the mentally ill in Asian culture than in Western culture, or a reaction of fear of the perceived potential dangerous behavior of the mentally ill in the U.S., as most of the Asian subjects were living in the U.S. temporarily. The greater forgiveness of deviant behavior among the Asians may be a result of a lesser emphasis on retribution in Asian culture than in Western culture.

Social Support

Five of the items involved a theme of social support or social factors in mental illness. In general, Asians believed more strongly that social support and kind treatment of others prevents mental illness and promotes mental health. This tendency may be because Asians are more family oriented and tend to live in a collective society.

Symptoms of Mental Illness

Six of the items involved a theme of symptoms of the mentally ill. These findings may suggest either that Asians are less informed about outward appearances and behavior of the mentally ill, or that in Asian cultures, the mentally ill do indeed look different from others. Also, in Asian cultures, alcoholism, agoraphobia and theft may not be viewed as psychological problems, or as problems at all, especially agoraphobia. Asian culture may place greater emphasis on home life and family ties than in Western culture, thus if fear of leaving the home occurs, the fear may be viewed as healthy.

Perceptions of Psychiatrists

Three of the items involved perceptions of psychiatrists. These items may suggest that Asians are unfamiliar with the capabilities and limitations of psychiatrists. In Asian culture, psychiatrists may not be the first choice of treatment for the mentally ill. Also, Asians may distrust young psychiatrists because of the greater respect Asian culture places in the wisdom of the elderly.

Severity

Three of the items involved a theme of severity of mental illness. These items may suggest that Asians view mental illness

as a severe problem for individuals, but not for the U.S. as a whole.

Vacation as a Cure

Two of the items involved the theme of vacations. These items suggest Asians find a temporary break from the typical routine and the typical environment and a few weeks spent in relaxation to be useful in overcoming mental illness. Asians may view the origin of mental illness to be in the environment more so than in the individual, if they believe a change of environment, like a vacation, can lead to mental health.

Miscellaneous

Four of the items did not seem to group into categories. These items suggest Asians view men as mentally stronger and healthier than women; Asians may be doubtful and pessimistic about overcoming mental illness; Asians may have a tendency to see a link between mental and physical illness; and finally, Asians are likely to view mental health as being in harmony with nature, and thus mental health includes being in touch with one's physical surroundings.

Items on which Asian, Hispanic and European Attitudes Did Not Differ

Asians, Hispanics and Europeans were found to share some similar attitudes toward mental illness. The 21 items on which the

three groups did not differ in their attitudes toward mental illness were categorized in terms of the content of the items. Nineteen of the items seemed to group into five categories, with two additional miscellaneous items. Again, it should be recognized no cross-validation was performed, and this discussion is tentative.

Biological Aspects and Mental Illness

Five of the items seemed to involve the separation of physical and mental processes. In general, a link between physical processes and mental disorder was rejected by all three groups. These particular items are not generally endorsed by the scientific and professional community, thus suggesting the sample population in this study was well informed about physical conditions that are generally unrelated to mental illness.

Cognitive Views and Mental Illness

Four of the items involved a theme of cognitions and mental illness. In general, the notion of a link between cognitions and mental illness was rejected.

Family Support

Four of the items involved a theme of family support. In general, lack of family support was not perceived to cause mental illness, but family support was seen to be beneficial in treating mental illness.

Emotions and Mental Illness

Three of the items involved a theme of emotions. The most interesting tendency in this category was that all groups believed early experiences contribute to mental illness. This tendency points to the importance placed on childhood as a period that can profoundly affect later life.

Symptoms Needing Treatment

Three of the items involved symptoms that need psychological treatment. These items suggest divorce is not viewed as a psychological problem and maybe not a problem at all. Also, all groups recognized that schizophrenic and schizoid behaviors warranted some psychological treatment.

Miscellaneous

Two items did not seem to group with the other items. These items suggest all three groups have little fear or stigmatized ideas that mentally ill people can be physically or psychologically dangerous to others, and that one's identity is in part determined by the social environment.

General Discussion

The aim of this study was to develop a scale to differentiate people from different cultural backgrounds based on their attitudes toward mental illness. The study was limited in

that the subjects were all college students at a southwestern university, thus increasing the likelihood the subjects were more homogeneous than heterogenous in terms of their cultural norms and the number of generations from their ethnic roots. Given these limitations, it is surprising to have found even 15 items that differentiate Hispanics and Europeans. Further research using noncollege populations may uncover further ethnic differences in attitudes toward mental illness.

As can be noted, Europeans, Hispanics and Asians had different attitudes toward certain aspects of mental illness. Sometimes, the three groups shared common attitudes about an aspect of mental illness, while they also had different attitudes about that very same aspect. For example, Europeans and Hispanics shared some common attitudes about biological aspects and hopefulness, and also disagreed about some items that tapped into biological aspects and hopefulness. Asians shared common attitudes with Europeans and Hispanics about thoughts, emotions, symptoms and social support, and Asians also disagreed with Europeans and Hispanics about thoughts, emotions, symptoms and social support.

These tendencies suggest at least three considerations. The first consideration is that the subjects in this study responded randomly to the items. Random responses could explain the inconsistent agreements and disagreements on items that seemingly group together into categories. The second consideration

is that people have unreliable attitudes toward mental illness. The subjects in this study may be unaware or uncertain of their attitudes. Thus they were lead by their uncertainties to respond inconsistently to items that seemingly were related.

The third consideration involves the fact that the definition of mental illness or mental disorder was not directly addressed in the study, nor in the directions to the subjects. Without a definition of mental illness in mind to focus their thoughts, the subjects may have been responding to numerous ideas of what mental illness means. Mental illness is a global term that encompasses many ideas. There are many different types of mental illness, such as schizophrenia or depression, with very different symptoms. Thoughts, emotions and behaviors may be different for each type of mental illness. Hope for alleviation from the mental illness may be different for each type. Biological aspects, needed social support, treatment, severity, stigma, origins and sex differences may be different for each type. Thus to use the term mental illness may have artificially simplified the concept. The items in this questionnaire, written from a European perspective, may not be relevant to Asians and Hispanics. For suggested future research, attitudes toward specific components of mental illness need to be examined. For example, understanding public attitudes toward biological aspects of mental illness may be more beneficial than understanding attitudes toward mental illness as a whole.

A single individual may have several idiosyncratic notions of mental illness, and groups of people may have several culturally specific notions of mental illness. Thus, a more general problem of cultural comparison exists in this study, and any study that compares cultures. Different cultures may have definitions or experiences of phenomena that are unique to each culture. Mental illness, mental disorder, behavioral deviance, or mental health may all be terms that are meaningful in one culture and meaningless in another culture. The entire concept of "mental illness" may have no meaning in Asian or Hispanic culture, thus comparing these cultures to European culture in regards to "mental illness" may be meaningless. Given that the term "mental illness" encompasses numerous concepts in any one culture, comparing the term "mental illness" alone across cultures ignores the numerous concepts that comprise "mental illness" within each culture. The term mental illness and what the term entails needs to be understood within each culture.

The methods by which cultural conceptions of mental illness are studied needs further consideration. Questionnaire taking is a culturally biased activity. The activity of filling out the questionnaires may have been an obnoxious, uncomfortable or meaningless task to the Hispanic and Asian subjects.

Hispanic, Asian and European groups responded by disagreeing with the great majority of the items. This negative

response bias may be due in part to the fact that some of the items were purposefully unusual to maximize the differences between ethnic groups. Also, some of the items may have been so out of the realm of any of the subjects' experiences, that the subjects disagreed out of a lack of understanding.

All the European subjects, half the Hispanic subjects, and a few of the Asian subjects were college students in an introductory psychology class. Thus, the majority of subjects may have had some knowledge of mental illness that may have influenced their responses. The fact that all the subjects were university students carries a further caution. College students are expected to be more knowledgeable than the general population. Thus, the questionnaire may have really been measuring attitudes of a middle class that places high importance on education. Ethnic differences may be more salient in people not committed to middle class values. More of the items may have been found to discriminate Europeans and Hispanics if a more representative sample had been employed. The effects of education, acculturation and age in interaction with ethnicity could be examined in a noncollege sample. Further investigation in this area is recommended.

Further investigation is also recommended with other ethnic groups. The attitudes about mental illness that differentiate Europeans, Hispanics and Asians may not differentiate Europeans, Hispanics and Asians from other ethnic

groups. Further investigation is also needed to cross-validate the findings concerning the Asian subjects.

In conclusion, the EMI Scale appears to be a reasonably good instrument to differentiate attitudes toward mental illness of college students of European and Hispanic ethnic backgrounds. Whether these differences will generalize to a noncollege sample of ethnic Europeans and Hispanics is not known. Given the homogeneity of a university sample, it is surprising that even 15 items were found to differentiate ethnic Hispanics and Europeans. The differences may be so small as to be meaningfully insignificant. Also, the difficulties of comparing across cultures need to be kept in mind. The information gained from this study can be used for community mental health purposes. Greater understanding of ethnic attitudes toward mental health and mental illness can aid in planning preventive, educational, and therapeutic interventions. With knowledge of an ethnic community's understanding of mental illness and mental health, community and clinical psychologists can fit what they have to offer to the community, rather than wait for the community's needs to fit what community and clinical psychologists can provide.

APPENDIX A

OPINIONS ABOUT MENTAL HEALTH QUESTIONNAIRE

Different people have different ideas about mental health and illness. These ideas may depend on a person's age, sex, culture or education. The more psychologists know about what people think about mental health, the better they can help prevent and treat mental illness. This set of items ask about some of your opinions about mental health and illness. There are no right or wrong answers. All the questionnaires are anonymous, and all responses will be kept strictly confidential. Please answer all items as best you can.

Thank you for your help.

Instructions

At the top of each page are numbers paired with a level of agreement. Next to each item, print the number which matches up with your agreement with the statement.

Example

1	2	3	4
Strongly Disagree	Slightly Disagree	Slightly Agree	Strongly Agree

__4__ Ex. The best way to stay mentally healthy is to stay physically healthy.

_____ 1. The mentally ill pay little attention to their personal appearance.

_____ 2. People who keep themselves occupied with pleasant thoughts seldom become mentally ill.

_____ 3. Few people who enter mental hospitals ever leave.

_____ 4. Older people have fewer emotional problems than younger people.

_____ 5. People cannot maintain good mental health without the support of strong persons in their environment.

_____ 6. Will power alone will not cure mental disorders.

_____ 7. Women have no more emotional problems than men do.

_____ 8. X-rays of the head will not tell whether a person is likely to become insane.

_____ 9. Emotional problems do little damage to the individual.

_____ 10. Psychiatrists try to teach mental patients to hold in their strong emotions.

_____ 11. Mental illness can usually be helped by a vacation or change of scene.

_____ 12. Disappointments affect children as much as they do adults.

_____ 13. The main job of the psychiatrist is to recommend hobbies and other ways for the mental patient to occupy his mind.

_____ 14. The insane laugh more than normal people.

_____ 15. Psychiatrists try to show the mental patient where his ideas are incorrect.

_____ 16. Mental disorder is not a hopeless condition.

_____ 17. Mental health is one of the most important national problems.

_____ 18. Mental disorder is usually brought on by physical causes.

_____ 19. It is easier for women to get over emotional problems than it is for men.

_____ 20. A change of climate seldom helps an emotional disorder.

_____ 21. The best way to mental health is by avoiding morbid thoughts.

_____ 22. There is not much that can be done for a person who develops a mental disorder.

_____ 23. Mental disorder is one of the most damaging illnesses that a person can have.

_____ 24. Children sometimes have mental breakdowns as severe as those of adults.

_____ 25. Nervous breakdowns seldom have a physical origin.

_____ 26. Most of the people in mental hospitals speak in words that can be understood.

_____ 27. Mental health is largely a matter of trying hard to control the emotions.

_____ 28. If a person concentrates on happy memories, he will not be bothered by unpleasant things in the present.

_____ 29. The mentally ill have not received enough guidance from the important people in their lives.

_____ 30. Women are as emotionally healthy as men.

_____ 31. The seriousness of the mental health problem in this country has been exaggerated.

_____ 32. Helping the mentally ill person with his financial and social problems often improves his condition.

_____ 33. Mental patients usually make a good adjustment to society when they are released.

_____ 34. The good psychiatrist acts like a father to his patients.

_____ 35. Early adulthood is more of a danger period for mental illness than later years.

_____ 36. Almost any disease that attacks the nervous system is likely to bring on insanity.

_____ 37. You can tell a person who is mentally ill from his appearance.

_____ 38. People who become mentally ill have little will power.

_____ 39. Women are more likely to develop mental disorders than men.

_____ 40. Most mental disturbances in adults can be traced to emotional experiences in childhood.

_____ 41. People who have little sexual desire are more likely to have a "nervous breakdown" than are other people.

_____ 42. A person can avoid worry by keeping busy.

_____ 43. A poor diet often leads to feeble-mindedness.

_____ 44. Emotionally upset persons are often found in important positions in business.

_____ 45. Good emotional habits can be taught to children in school as easily as spelling can.

_____ 46. The eyes of the insane are glassy.

_____ 47. When a person is recovering from a mental illness, it is best not to discuss the treatment that he has had.

_____ 48. People who go from doctor to doctor with many complaints know that there is nothing really wrong with them.

_____ 49. A person cannot rid himself of unpleasant memories by trying hard to forget them.

_____ 50. The main job of the psychiatrist is to explain to the patient the origin of his troubles.

_____ 51. Most suicides occur because of rejection in love.

_____ 52. People who are likely to have a nervous breakdown pay little attention to their personal appearance.

_____ 53. Most of the time psychiatrists have difficulty in telling whether or not a patient's mental disorder is curable.

_____ 54. Children usually do not forget about frightening experiences in a short time.

_____ 55. Books on "peace of mind" prevent many people from developing nervous breakdowns.

_____ 56. Most clergymen will encourage a person with a mental disorder to see a psychiatrist.

_____ 57. Physical exhaustion does not lead to a nervous breakdown.

_____ 58. The adult who needs a great deal of affection is likely to have had little affection in childhood.

_____ 59. Physical rest will not prevent a mental disorder.

_____ 60. Most of the people who seek psychiatric help need the treatment.

_____ 61. Mental illness is something that runs in families.

_____ 62. A psychiatrist is able to understand you no matter how little you cooperate with him.

_____ 63. The mental hospital is where you go when you are tired and physically run down.

_____ 64. Once you have been in a mental hospital people treat you like you are peculiar or different.

_____ 65. It's always possible that one might be hurt by other patients in a mental hospital.

_____ 66. The principle reason for mental hospitals is to get the mentally disturbed person out of the publics' eye.

_____ 67. The mental hospital is a place to get away from your problems.

_____ 68. A person is more likely to be hurt than helped in a mental hospital.

_____ 69. Most psychiatrists are too young to know what they are doing.

_____ 70. A mentally well person is one who is liked and appreciated by everybody.

_____ 71. Mental health troubles could be cured by the right drug.

_____ 72. Mental hospitals are like a prison for keeping people locked up.

_____ 73. A mental hospital is a place where patients can benefit mainly by receiving three well-balanced meals a day.

_____ 74. The mental hospital is like a vacation at a resort.

_____ 75. A person is deprived of most of his rights while in a mental hospital.

_____ 76. Mental hospitals may help some patients but quite a few are discharged without real improvement.

_____ 77. A mentally well person is one that keeps his feelings and his emotions to himself.

_____ 78. Once you've been in a mental hospital people won't ever treat you the same as they did before your mental illness.

_____ 79. If people were left alone they could avoid mental illness.

_____ 80. Once having been mentally ill you should be excused for many things you do.

_____ 81. A person has little to say about when he will be released from a mental hospital.

_____ 82. Mental illness is due to past experiences people have had with other people.

_____ 83. A mental hospital is the best place to let go your emotions.

_____ 84. If a woman is not careful when pregnant, her children may have emotional problems later in life.

_____ 85. Bad dreams and nightmares can cause mental disorders.

_____ 86. Mental disorders can be passed down from parents to children.

_____ 87. Mental disorders can be a punishment for things a person's ancestors did.

_____ 88. God doesn't punish people for their sins by making them mentally disordered.

_____ 89. People become mentally disordered because they do bad things to other people.

_____ 90. Mental disorders are caused by possession by the devil.

_____ 91. A person's family may sometimes cause someone to become mentally disordered.

_____ 92. Too much stress and pressure at work can cause a person to become mentally disordered.

_____ 93. Bad marriages can cause the husband or wife to become mentally disordered.

_____ 94. If someone is treated cruelly by other people that person can become depressed and mentally disordered.

_____ 95. Having a lot of friends can prevent someone from becoming mentally disordered.

_____ 96. There are some people who will never be mentally disordered because of their outlook on life.

_____ 97. Mental disorders can be described as losing touch with one's soul.

_____ 98. Mentally disordered people think differently than other people.

_____ 99. Giving up in the face of problems can lead to mental disorders.

_____ 100. A mentally disordered person needs someone to look after them at all times.

_____ 101. One's clergyman can sometimes be more helpful than a psychologist if one is in emotional distress.

_____ 102. It is important to seek treatment for mental disorders as soon as possible.

_____ 103. People who do not seek help for mental problems lose all hope of ever getting better.

_____ 104. Psychological treatment can hurt more than it helps.

_____ 105. Most people get better after seeking treatment for mental disorders.

_____ 106. Even a short time in treatment helps a mentally disordered person to get better.

_____ 107. Treatment for mental disorders should include the whole family, not just one person.

_____ 108. Many different kinds of treatment should be used to help a mentally disordered person.

_____ 109. People can become mentally disordered because they don't get along well with their families.

_____ 110. People with mental disorders need to place total trust in their therapist to get better.

_____ 111. People with mental disorders need to learn how to be more independent.

_____ 112. The shorter therapy takes, the better.

_____ 113. If people treated each other with care and respect there would not be mental disorders.

_____ 114. Children become emotionally disturbed if they are treated unkindly.

_____ 115. If a mentally disordered person is able to hold a job, then there is really nothing wrong with him or her.

_____ 116. Psychologists are able to read minds.

_____ 117. One should not put up with the behavior of mentally disordered people.

_____ 118. Mentally disordered people do not really act any different from other people.

_____ 119. It is all right to spend time with mentally disordered people.

_____ 120. Mentally disordered people can work side by side with other people.

_____ 121. I would feel uncomfortable if people knew someone in my family was mentally disordered.

_____ 122. I would not mind living next door to a mental hospital.

_____ 123. It is important for mentally disordered people to live at home.

_____ 124. The people best suited to help a mentally disordered person is that person's family.

_____ 125. If a person's surroundings are bad, then that person cannot help but be mentally disordered.

_____ 126. Mental disorders are really just something going wrong with your body that makes you act differently.

_____ 127. Mental health is to be in balance with nature.

_____ 128. If you can find what's wrong with the body, you can cure mental disorders.

_____ 129. Treating the mind and the body are one and the same.

_____ 130. The best cure for mental disorders is prayer.

_____ 131. Thinking bad or weird thoughts can cause someone to become physically ill.

_____ 132. The way other people treat us affects our emotions.

_____ 133. The way I treat people can have a large affect on their emotions.

_____ 134. Who we are is in part determined by the people around us.

_____ 135. Every person is unique and different from every other person.

_____ 136. The opinions of mentally disordered people are valuable because they see the world in a different way.

_____ 137. People who are very talented think in strange or bizarre ways.

_____ 138. A person who has overcome a mental disorder is always close to another breakdown.

_____ 139. People with mental disorders should not be allowed to have children.

_____ 140. People should seek psychological treatment if they hear voices that aren't really there.

_____ 141. People do not need psychological treatment if they are sad and tired all the time.

_____ 142. People who feel like they are going to faint if they leave their house do not need psychological treatment.

_____ 143. People should seek psychological treatment if they drink too much alcohol.

_____ 144. People who steal need psychological treatment.

_____ 145. Menopause can make a woman become mentally disordered.

_____ 146. People who have lost faith in God don't necessarily need psychological treatment.

_____ 147. People who don't trust anyone and think everyone is out to get them should seek psychological treatment.

_____ 148. People don't need psychological treatment if they are withdrawn and have no friends.

_____ 149. People who get divorced more than twice should seek psychological treatment.

_____ 150. People who are tense all the time and do not know how to relax should seek psychological treatment.

Finally, we would like to ask you a few questions about yourself. We thank you for your help in filling out this questionnaire.

1. I am a
   _____ 1) male.
   _____ 2) female.

2. My age is _______ years old.

3. The ethnic group which is part of my background is

_____ 1) American Indian	_____ 2) Arabic	_____ 3) Black American
_____ 4) Chinese	_____ 5) Cuban	_____ 6) English
_____ 7) Filipino	_____ 8) German	_____ 9) Irish
_____ 10) Italian	_____ 11) Japanese	_____ 12) Jewish
_____ 13) Korean	_____ 14) Mexican	_____ 15) Polish
_____ 16) Puerto Rican	_____ 17) Scandinavian	

_____ 18) Other (please specify) ______________________________

5. The first people to permanently settle in the United States were
   _____ 1) my great-grandparents or beyond.
   _____ 2) my grandparents.
   _____ 3) my parents.
   _____ 4) myself.
   _____ 5) I am living in the United States temporarily.
   _____ 6) I don't know.

6. The language spoken in the home in which I grew up was
   _____ 1) English.
   _____ 2) Other (please specify) ____________________________.
   _____ 3) English and some other language (please specify) _____________.

7. The language in my current home is
   _____ 1) English.
   _____ 2) Other (please specify) ____________________________.
   _____ 3) English and some other language (please specify) _____________.

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