THE UNIVERSITY OF MANITOBA

A STUDY OF COMMUNITY ATTITUDES TOWARD DISCHARGED PSYCHIATRIC PATIENTS: IMPACT OF PATIENT HOUSING ON PUBLIC ATTITUDES

by

ANNA RUTH LOEWEN

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Anne Loewen

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A Study of Community Attitudes Toward Discharged Psychiatric Patients: Impact of Patient Housing on Public Attitudes

ABSTRACT

This study considered a variety of sheltered care facilities for the discharged psychiatric patient, and examined public tolerance and acceptance of patient housing.

The public is most receptive to community based housing for the mentally ill in which a single patient resides with a foster family, or when the former patient is living in independent housing. Least acceptable to the neighborhood residents is a halfway house for former patients.

Community residents living in neighorhoods of the "Independent Group Homes", generally expressed more accepting and tolerant attitudes toward the mentally ill, than did community residents living in neighborhoods of other types of housing studies, as measured by the community housing scale, the social distance scale, on general attitude statements, and by the Star Vignettes.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

ABSTRACT

LIST OF TABLES

CHAPTER PAGE

I. INTRODUCTION

STATEMENT OF THE PROBLEM 1

II. REVIEW OF THE LITERATURE

COMMUNITY ATTITUDES TOWARD THE MENTALLY ILL. . . 5

Research Prior to 1960 7

Research in the Sixties 12

Research Since 1970 19

COMMUNITY RESPONSE TO SHELTERED CARE FACILITIES. 22

SUMMARY OF FINDINGS 26

FACTORS AFFECTING PUBLIC ATTITUDES 27

RELATIONSHIP BETWEEN ATTITUDES AND BEHAVIOUR . . 29

COMMUNITY RESPONSE AS A FUNCTION OF TYPE OF HOUSING 31

III. METHOLOGY

SAMPLING PROCEDURES 33

QUESTIONNAIRE CONSTRUCTION 34

QUESTIONNAIRE ADMINISTRATION 36

CHAPTER PAGE

IV. RESULTS AND DISCUSSION 38

SAMPLE DESCRIPTION: DEMOGRAPHIC CHARACTERISTICS. 38

SAMPLE DESCRIPTION: SOCIO-ECONOMIC CHARACTERISTICS 42

LEVELS OF EXPEREIENCE WITH DISCHARGED PSYCHIATRIC PATIENTS 45

HOUSING IMPACT: DIFFERENCES IN VISIBILITY . . . 47

HOUSING IMPACT: COMMUNITY REACTION TO TYPE OF HOUSING 48

COMMUNITY REACTION: SOCIAL DISTANCE ITEMS . . . 52

COMMUNITY HOUSING: REACTION TO SOCIAL DISTANCE ITEMS 55

COMMUNITY REACTION: RESPONSE TO GENERAL ATTITUDE STATEMENTS 57

SUMMARY OF GENERAL ATTITUDE STATEMENTS 65

STAR VIGNETTES: IMPACT OF HOUSING ON ATTITUDES . 66

V. STUDY CONCLUSIONS AND IMPLICATIONS 71

APPENDICIES

BIBLIOGRAPHY

LIST OF TABLES

TABLE		PAGE
I.	DISTRIBUTION OF RESPONDENTS BY AGE AND SEX	38
II.	DISTRIBUTION OF RESPONDENTS BY MARITAL STATUS AND SEX	39
III.	DISTRIBUTION OF RESPONDENTS BY EDUCATION	40
IV.	DISTRIBUTION OF RESPONDENTS BY RELIGIOUS PREFERENCE	40
V.	DISTRIBUTION OF RESPONDENTS BY ETHNIC ORIGIN	41
VI.	DISTRIBUTION OF RESPONDENTS BY INCOME	42
VII.	DISTRIBUTION OF RESPONDENTS BY SEX AND TYPE OF JOB	43
VIII.	MEAN EXPERIENCE SCORE OF RESPONDENTS BY RESIDENCE TYPE	46
IX.	PERCENTAGE OF RESPONDENTS AWARE OF DISCHARGED PATIENTS LIVING IN THE COMMUNITY BY HOUSING TYPE	47
X.	MEAN SCORES ON SOCIAL DISTANCE ITEMS BY RESIDENCE TYPE	55
XI.	PERCENTAGE OF RESPONDENTS REPLYING TO THE STATEMENT THAT MOST DISCHARGED PSYCHIATRIC PATIENTS ARE WILLING TO WORK BY RESIDENCE TYPE	60
XII.	PERCENTAGE OF RESPONDENTS ABLE TO IMAGINE THEMSELVES FALLING IN LOVE WITH A FORMER PSYCHIATRIC PATIENT BY RESIDENCE TYPE	62
XIII.	PERCENTAGE OF RESPONDENTS RESPONDING TO THE STATEMENT THAT DISCHARGED PSYCHIATRIC PATIENTS SHOULD BE ALLOWED TO MARRY BY RESIDENCE TYPE.	63
XIV.	PERCENTAGE OF RESPONDENTS RESPONDING TO THE STATEMENT THAT DISCHARGED PATIENTS ARE MORE DANGEROUS THAN THE GENERAL POPULATION BY RESIDENCE TYPE	65
XV.	MEAN REJECTION OF CASE DESCRIPTIONS OF MENTAL ILLNESS BY RESIDENCE TYPE	67

LIST OF TABLES

TABLE		PAGE
I.	DISTRIBUTION OF RESPONDENTS BY AGE AND SEX	38
II.	DISTRIBUTION OF RESPONDENTS BY MARITAL STATUS AND SEX	39
III.	DISTRIBUTION OF RESPONDENTS BY EDUCATION	40
IV.	DISTRIBUTION OF RESPONDENTS BY RELIGIOUS PREFERENCE	40
V.	DISTRIBUTION OF RESPONDENTS BY ETHNIC ORIGIN	41
VI.	DISTRIBUTION OF RESPONDENTS BY INCOME	42
VII.	DISTRIBUTION OF RESPONDENTS BY SEX AND TYPE OF JOB	43
VIII.	MEAN EXPERIENCE SCORE OF RESPONDENTS BY RESIDENCE TYPE	46
IX.	PERCENTAGE OF RESPONDENTS AWARE OF DISCHARGED PATIENTS LIVING IN THE COMMUNITY BY HOUSING TYPE	47
X.	MEAN SCORES ON SOCIAL DISTANCE ITEMS BY RESIDENCE TYPE	55
XI.	PERCENTAGE OF RESPONDENTS REPLYING TO THE STATEMENT THAT MOST DISCHARGED PSYCHIATRIC PATIENTS ARE WILLING TO WORK BY RESIDENCE TYPE	60
XII.	PERCENTAGE OF RESPONDENTS ABLE TO IMAGINE THEMSELVES FALLING IN LOVE WITH A FORMER PSYCHIATRIC PATIENT BY RESIDENCE TYPE	62
XIII.	PERCENTAGE OF RESPONDENTS RESPONDING TO THE STATEMENT THAT DISCHARGED PSYCHIATRIC PATIENTS SHOULD BE ALLOWED TO MARRY BY RESIDENCE TYPE.	63
XIV.	PERCENTAGE OF RESPONDENTS RESPONDING TO THE STATEMENT THAT DISCHARGED PATIENTS ARE MORE DANGEROUS THAN THE GENERAL POPULATION BY RESIDENCE TYPE	65
XV.	MEAN REJECTION OF CASE DESCRIPTIONS OF MENTAL ILLNESS BY RESIDENCE TYPE	67

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By Anne Loewen

CHAPTER I

INTRODUCTION

STATEMENT OF PROBLEM

Our intent is to explore community attitudes toward discharged mental hospital patients, and the possible effect of after-care facilities on community attitudes.

As the shift to a community approach in the treatment of psychiatric hospital patients continues, replacing the traditional mental hospital services, knowledge of community attitudes becomes critically important to those involved in placing ex-patients into the community. If those responsible for the planning and carrying out of treatment programs do not take into account the realities that the patients face in their daily living, they miss an important element of the discharged patient's successful re-entry into community living. Cohen and Struening (1962) commented that:

> This outlook is based on the assumption that the well-being of mental patients is at least to some extent influenced by the social context. . . the success of re-integrating former mental patients into society is affected by the attitudes of the general public toward mental illness.[1]

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1. J. Cohen and E.L. Struening, "Opinions about Mental Illness in the Personnel of Two Large Mental Hospitals." Journal of Abnormal Psychology, 1962, 64: 349.

Recent reports in a Winnipeg newspaper have suggested that community attitudes are not favourable to the housing of ex-mental hospital patients within some communities.[2] If discharged patients are placed into these communities, but are rejected by the general public, their successful re-adjustment to community living may be severely hampered.

Studies in social psychiatry have shown that social integration into satisfying interpersonal networks has important implications for the mental health of individuals.[3] Other studies have looked at the presence of discharged patients in the community to determine if they were "really in the community", that is, taking part in normal community functions, or if they were merely being housed in the community, but excluded from participation.[4]

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2. Winnipeg Free Press, August 26, 1975; September 16, 1975, reported that community reaction to the establishing of a halfway house in one area was so negative that the issue was defeated, and that the halfway homes in another area were considered to be "resulting in an increasing degeneration of the area".

3. Alexander H. Leighton, People of Cove and Woodlot: Communities from the Viewpoint of Social Psychiatry, Vol. II of the Sterling County Study of Psychiatric Disorder and Socio-Cultural Environment (New York: Basic Books, Inc., 1960), p. 146.

4. H.R. Lamb and V. Goertzel, "Discharged Mental Patients--Are They Really in the Community?" Archives of General Psychiatry 1971, 24: 29-33; Uri Aviram and S.P. Segal, "Exclusion of the Mentally Ill", Archives of General Psychiatry 1973, 29: 126-31; and in B. Trute, "Social Indicators as Predictors of Social Integration in Saskatchewan and California", Doctoral Dissertation, University of California at Berkeley, 1975.

The major hypothesis of this study is that the type of community residence utilized by the mentally ill may influence public response to people who have had a history of psychiatric care.

The present study will examine the effects of four types of ex-mental patient housing on community attitudes.

Foster-family care is used in this study to refer to that type of after-care facility in which an ex-mental patient is accepted into a private home as a paying guest. The usual purpose for family/foster care is to provide long-term care and supervision for those unable to care for themselves.

Board and care homes are those after-care facilities in the community housing two to three discharged psychiatric patients, usually under the supervision of a landlady.

Larger board and care homes, as used in this study, refers to those facilities in which more than four ex-mental hospital patients are housed. The homes are residential facilities designed to meet the needs of ex-mental patients during the transition from the sheltered hospital environment to community living. Their purpose is to provide a protective, temporary environment to assist the formerly hospitalized mental patient to function in the community. There is round the clock supervision.

The concept of "Group Homes for Independent Living" is a relatively new concept in Winnipeg, and is the fourth type of after-care facility this study will consider. The independent

living situation is one in which ex-mental patients live in small groups without live-in staff, and with limited supervision. The residents are responsible for their own tasks of daily living (e.g., laundry, shopping, cooking, etc.). The roles assigned to the ex-patient in the Independent Group Homes allow them to function in a way that is considered to be the norm in the larger community.

Community attitudes toward the discharged psychiatric patient will be studied to ascertain if these attitudes are a function of the type of after-care facility utilized by the formerly mentally ill in the community. That is, the study will explore the effect that different types of housing for the discharged mental patient has on the general attitudes held by neighbors residing near the facility in which the ex-patient is placed.

CHAPTER II

A REVIEW OF THE LITERATURE

COMMUNITY ATTITUDES TOWARDS THE MENTALLY ILL

A sizeable body of research has emerged during the past twenty years in the area of social attitudes toward mental illness and the mentally ill. Parsons (1957) suggested that the focus of disturbance in mental illness is in the relations between the personality of the individual and the social system or systems in which he participates. He defines a mentally ill person as "a person who by definition cannot get along with his fellows, who presents a problem to them directly on the behavioural levels."[5] Parsons felt that "American society values put a primary emphasis on achievement, and that it is chiefly because mental illness hinders effective achievement that in our society, it is defined as an undesirable state."[6] The mentally ill may exhibit forms of behaviour which are directly in conflict with the culturally accepted rules and norms, thereby becoming a threat to society's values.

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5. T. Parsons, "The Mental Hospital as a Type of Organization", in M. Greenblatt, D.J. Levinson, and R.H. Williamson (Eds.), The Patient in the Mental Hospital. (Glencoe, Illinois: Free Press, 1957), p. 109.

6. Ibid, p. 112.

Askensay (1974), in his study of attitudes toward the mentally ill, felt that society has different views and attitudes:

> The mental patient may be viewed as a deviant who fails to fulfill normative social expectations, and as a threatening figure who must be kept at a distance. On the other hand, he may be seen as a "sick person", and as such he may be entitled to a certain amount of help and understanding. The expressed attitude toward the mentally ill will therefore vary within the context with which he is regarded.[7]

Although approaches to the elucidation of attitudes have varied slightly, most have used a similar dependent measure--a social distance scale, to measure the extent to which the public rejects social intimacy with the former partient. Surveys have been conducted in an attempt to define attitudes toward the mentally ill by measuring the public's knowledge of various aspects of mental illness, by responses to statements about mental illness and the mentally ill, and by the desire to maintain social distance between the public and the psychiatric patient.

The majority of studies have illustrated generally negative and rejecting attitudes regarding discharged mental hospital patients. Studies reporting more positive findings have formed a minority opinion.

Rabkin (1974), in her review of the literature suggested that an ex-mental hospital patient returning home is more of a liability than being an ex-criminal in pursuit of housing, jobs,

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7. Alexander Askensay, Attitudes Toward Mental Health, (The Hague, Netherlands: Mouton & Co., 1974), p. 14.

and friends.[8] She further suggested that discharged mental hospital patients are regarded with more distaste and less sympathy than any other disabled group in society, and so are subject to public attitudes of rejection and avoidance.

The review of the literature presented here will look at some of the major studies in the area of social attitudes toward mental illness and the mentally ill, to give a perspective on what has been done and what changes have taken place in this area of study.

Research Prior to 1960

One of the first efforts to systematically investigate public attitudes toward mental illness was a study carried out in 1947 by Ramsey and Seipp.[9] They interviewed a broadly representative sample of Trenton, New Jersey concerning the etiology and the treatment of mental disorders. They correlated their data by sex, race, age, education level, and religion, and found that, in general, those factors which determine the respondent's educational-occupational level were also the main determinants of the degree of knowledge concerning mental health topics covered in the survey. The findings of this study

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8. Judith Rabkin, "Public Attitudes Toward Mental Illness: A Review of the Literature", Schizophrenia Bulletin (Fall), 1974, 10: 11.

9. G.V. Ramsey and M. Seipp, "Attitudes and Opinions Concerning Mental Illness", Psychiatric Quarterly, 1948, 22: 428-444.

are limited, however, because of the restricted concepts of etiology reflected in the questions.

A major study of attitudes was a survey conducted throughout the United States by Dr. Shirley Star at the National Opinion Research Centre of the University of Chicago in 1950. She used vignettes of six case descriptions of mentally ill persons to elucidate attitudes, and established a baseline of public resistance to the perception or labelling of mental illness that has served as a standard for measuring attitude changes since that time.[10] She concluded, as a result of her findings, that "only extreme psychosis accompanied by threatening, assaultive behaviour in its actual working definition of mental illness was included in people's perception about mental illness".[11] She found that people tended to resist calling anyone "mentally ill", and did so only as a last resort, and that differences in attitudes were traceable to social factors. Her study revealed that proof of mental illness was established on the basis of three criteria: 1) loss of cognitive function, 2) loss of

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10. Dr. Shirley Star's findings and vignettes were cited in an unpublished monograph, "The Dilemas of Mental Illness", reported in Action for Mental Health. Final Report of the Joint Commission on Mental Illness and Health (New York: Basic Books, Inc., 1961), p. 75. The case descriptions included a paranoid schizophrenic, a simple schizophrenic, alcoholic, and a childhood behaviour disorder.

11. Dr. Star quoted in Guido Crocetti, et al. Contemporary Attitudes Toward Mental Illness (University of Pittsburgh Press, 1974), p. 13.

self-control, and 3) inappropriate behaviour beyond what could be explained in a rationalistic basis. Star stated that the beliefs and attitudes of the public were a "real hinderance to the readjustment of recovered patients in normal society".[12]

Perhaps the most comprehensive study of social attitudes toward the mentally ill was a field experiment in mental health education done by John and Elaine Cumming (1951) in a small Canadian town, and reported on in their book Closed Ranks.[13] The Cummings' felt that persons returning from mental hospitals are often feared, unwanted, and isolated, and that if these feelings were changed, more successful rehabilitation of former patients would be favoured. Their pre-test, education, post-test technique was an attempt to understand and to change attitudes toward mental health and mental illness through an intensive educational program. They used a modified Guttman Scale to measure attitudes of distance and social responsibility.

Their education program failed, and the authors felt that the community's rejection of former mental hospital patients and its tolerance of poor hospital conditions and patient isolation served an important function for the society. They

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12. Shirley Star, "What the Public Thinks about Mental Health and Mental Illness". Unpublished paper presented to the annual meeting of the National Association for Mental Health, Inc., November 19, 1952.

13. Elaine and John Cumming, Closed Ranks: An Experiment in Mental Health Education. (Cambridge, Mass.: Harvard University Press, 1957).

concluded that the public's attitude was one of "denial, isolation, and insulation of mental illness".[14] Although the education program failed, the researchers found that the average person in the community is willing to live in the same neighborhood with former mental hospital patients, but stops short of rooming with one, and denies willingness for a close association. The major cause for rejection seemed to occur as soon as behaviour becomes non-normative and non-predictable.

Woodward (1951) in a study in Louisville, Ky. found that there was a general lack of recognition of psychiatric problems and that the public they sampled was not inclined to think in psychiatric terms about behaviour which the researchers regarded as pathological. The population studied, while reluctant to think in psychiatric terms, expressed alarm about the amount of mental illness in their community.[15]

Whatley (1959) investigated the social consequences of hospitalization in Louisiana using social distance items and concluded that discharged psychiatric patients were returning to "social unhealthy environments. . . and risking a certain amount of social isolation through curtailed interaction opportunities in primary groups".[16] He demonstrated that people

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14. Ibid., p. 114.

15. J.L. Woodward, "Changing Ideas on Mental Illness and Its Treatment". American Sociological Review, 1951, 16: 443-454.

16. C. Whatley, "Social Attitudes Toward Discharged Mental Patients". Social Problems, 1958-59, 6: 319.

tend to keep a distance between themselves and former patients, which creates a type of social isolation for the discharged patient that magnifies their problem of social re-adjustment. In general, they found that people rejected contact with ex-patients in situations of closeness, and were more accepting in relatively impersonal situations.

Nunnally (1961) carried on a five year study directed toward the measurement of public attitudes in regard to mental illness.[17] A sample survey was conducted to assess the popular attitudes, both those of the general population and those of the psychiatric profession, in central Illinois. He used a semantic differential to test "attitudes", and concluded his study by saying that "as is commonly suspected, the mentally ill are regarded with fear, distrust, and dislike by the general public".[18] He felt that the public is generally uninformed, and that all tend to regard the mentally ill as dangerous, dirty, worthless, and unpredictable. He suggested that the unpredictability of the mentally ill causes anxiety, which accounts for why "people are very uncomfortable in the presence of someone who is, or is purported to be, mentally ill".[19] Nunnally found that the stigma associated with mental illness was general,

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17. J.C. Nunnally, Popular Conceptions of Mental Health: Their Development and Change. (New York: Holt, Rinehart and Winston, Inc., 1961).
18. Ibid, p. 46.
19. Nunnally, Ibid, p. 233.

across social groups, types of mental illness, and that some of the negative attitudes were partially supported by facts (i.e. they sometimes are unpredictable).

Rabkin (1974) stated that "by 1960 it was unambiguously established that mental patients were dimly regarded in the public view".[20] It was felt that the public rejected, stigmatized, and shunned a person labelled as mentally ill. The Cummings' had reached a similar conclusion on the basis of their study in the early fifties, that there is a tendency on the part of the general public, once an individual has been identified as mentally ill, to "isolate" him and then to "reject" him. The social stigma of mental illness was a real and persistent problem, despite efforts to combat it.

The Joint Commission on Mental Illness and Health (1960) concluded that the public "does not feel as sorry as they do relieved to have out of the way persons whose behaviour disturbs and offends them."[21]

Research in the Sixties

Research on social attitudes toward the mentally ill in the sixties fell into two categories: those whose studies reported more optimistic findings about the public willingness

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20. Rabkin, Ibid., 1974, p. 12.

21. Final Report of the Joint Commission on Mental Illness and Health. Action for Mental Health (New York: Basic Books, Inc., 1961), p. 58.

to associate with the mentally ill, and those whose findings did not share the optimistic orientation. Crocetti (1974) summed up the situation by saying:

> There are those who see society as rejecting the mentally ill, displaying hostility toward them and closing its ranks against them; and those who believe that society is generally accepting of the mentally ill, is compassionate toward them, and is willing to accept them into its ranks.[22]

A study by Lemkau and Crocetti (1962) in Baltimore in 1961 was designed to "explore the readiness of the population to accept a program of home care for the discharged psychiatric patients."[23] Their sample was stratified by age, race, education, and income. Their attitude measures included Star Vignettes, a social distance scale, and some additional questions to examine opinions of the general public towards the mentally ill. They not only reported an increased ability to identify mental illness, but also did not regard the social distance placed between the mentally ill persons and the respondents to be highly significant. For evidence, they reported that 50% of their sample said that they "could imagine themselves falling in love with someone who had been mentally ill"; 81% said they wouldn't hesitate "to work with someone who

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22. Guido Crocetti, et al., Contemporary Attitudes Toward Mental Illness (University of Pittsburgh Press, 1974), p. xii.

23. P. Lemkau and G. Crocetti, "An Urban Population's Opinion and Knowledge about Mental Illness". American Journal of Psychiatry, 1962, 118: 692-700. Similar findings were also reported in G. Crocetti and P. Lemkau, "Public Opinion of Psychiatric Home Care in an Urban Area", American Journal of Public Health, 1963, 53: 409-416.

had been mentally ill": and 85% agreed that "people with some kinds of mental illness can be taken care of at home."[24] They further ascertained that their results varied "on a wide range of points from many previous studies using identical or similar questions and comparable methodology."[25]

Meyer (1964), replicating Lemkau and Crocetti's Baltimore study in Easton, Maryland, also concluded that the public had developed greater tolerance toward the mentally ill. He felt that "the population sampled is rational and humane in its verbally expressed attitudes toward mental illness. . . and apparently a significant change in verbally expressed attitudes toward mental illness has occurred in the past twn years."[26] Favourable attitudes reported in his study were such as: 78% did not feel that all mental patients were dangerous; 89% were in favour of home care for patients when appropriate. However, in social distance items involving a close personal relationship, only 45% disagreed with the statement "we would strongly discourage our children from marrying anyone who had been mentally ill", and only 55% would be "willing to room with someone who had been mentally ill".

The relationship between expressed social distance and acceptance or rejection of the mentally ill was neatly illustrated

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24. P. Lemkau, Ibid., 1962, p. 698.

25. Ibid.

26. Jon Meyer, "Attitudes Toward Mental Illness in a Maryland Community", Public Health Reports, 1964, 79: 772.

in a 1963 study of attitudes in Brandford, Connecticut by Derek Phillips.[27] Using the Star vignettes and a "normal" case description of his own, his respondents were told that the persons described had never sought help, or alternatively, to be former mental hospital patients. The study's results indicated that there still "exist relatively strong negative attitudes toward ex-mental patients."[28] Once the respondent in the study was informed that the person in the case description was an ex-mental hospital patient, their willingness to associate with him decreased. For example, 98% were willing to let their daughter marry the "normal", in contrast to only 17% willing to allow such a close relationship once they were told that the same "normal" had once been a patient in a mental hospital.

From his studies (1963, 1966) Phillips concluded that a history of mental hospitalization has a strong stigmatizing effect, and that "the source of help sought by mentally disturbed individuals appears to be strongly related to the degree to which others in the community reject him".[29] He felt that the labelling of behaviour as "mental illness" was associated with rejection. His studies documented his conviction that deviant behaviour labelled mental illness continues to be avoided and

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27. Derek Phillips, "Public Identification and Acceptance of the Mentally Ill." American Journal of Public Health, 1966, 56: 755-763.

28. Ibid., p. 762.

29. Derek Phillips, "Rejection: A Possible Consequence for Seeking Help for Mental Disorders", American Sociological Review, 1963, 28: 971.

rejected by the great majority of people. The degree of rejection expressed is dependent on the source of help, the visibility of the disturbed behaviour, and the gender[30] of the disturbed person. Phillips suggested that the

> Public are frequently unwilling to associate with mentally ill individuals and that although the public may at times report attitudes of support and understanding for those who have been in mental hospitals, the majority of studies document the stigmatizing influence of such an experience.[30]

Halpert (1965, 1969, 1970) in a series of articles on public attitudes suggested that there was increased public understanding in regards to psychiatric patients, and that attitudes were no longer as negative.[32] He felt that people's attitudes and behaviour when confronted with their own or other's emotional difficulties were affected by their personal orientation to deviant behaviour, the extent of liberalism in one's general outlook, one's occupational frame of reference, social customs, and the needs of the person. He also felt that the combination of

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30. In Derek Phillips, "Rejection of the Mentally Ill: Influence of Behaviour and Sex", American Sociological Review, 1964, 29: 679-687, he found that males are more heavily stigmatized for deviant behaviour than are females.

31. Derek Phillips, "Identification of Mental Illness: Its Consequences for Rejection", Community Mental Health Journal, 1967, 3: 762.

32. H.P. Halpert, "Surveys of Public Opinions and Attitudes About Mental Illness", Public Health Reports 80: 589-597, 1965; H.P. Halpert, "Public Acceptance of the Mentally Ill", Public Health Reports 84: 59-64, 1969; Also in an article by H.P. Halpert "Public Opinion and Attitudes About Mental Health" in Social Psychology and Mental Health, H. Wechsler, L. Solomon, and B.M. Kramer (Ed.), Holt, Rinehart & Winston, Inc., 1970, pp. 489-504.

these affected the discharged psychiatric patient when he returned to community living and was met with the realities of his social environment.

> Public understanding and favourable attitudes are essential for optimum utilization of new types of mental health facilities and for acceptance of the greater number of mentally ill persons who can now be treated in the community.[33]

Dohrenwend and Chin-Shong (1967), based on their findings from two studies in New York (community leaders 1960-61; residents 1963-64), concluded that "the leaders expressed less social distance for ex-mental patients than cross-section respondents at all education levels".[34] In response to social distance items, 94% of the leaders disagreed with barring former patients from the community, compared to 82% of the public; 86% of the leaders disagreed with hesitating to rent living quarters to ex-patients compared to 54% of the public disagreeing; and 55% of the leaders would trust their children with a former patient, compared with only 26% of the public trusting theirs.

Rootman and LaFave (1969) in a small rural Canadian town, compared findings with those of Lemkau and Crocetti (1962) and Cummings (1955). The comparison led the authors to conclude that "attitudes are changing" and that their sample population seemed "to possess more knowledge about mental

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33. Halpert, Ibid., 1969, p. 59.

34. B.P. Dohrenwend and E. Chin-Shong, "Social Status and Attitudes Toward Psychological Disorder: The Problem of Tolerance of Deviance". American Sociological Review 32: 417-433, 1967.

illness. . . and to place less social distance between themselves and the mentally ill".[35] They cautioned their readers, however, that increasing sophistication about mental illness may not be tantamount to increased tolerance toward the mentally ill.[36]

Edgerton and Bentz (1969) in a study of attitudes toward mental illness and the mentally ill among rural people, reported the same "enlightened" attitudes as reported by Lemkau and Crocetti (1962) in their study among urban people.[37] They studied the leaders and the general public from the same North Carolina counties and concluded that, in general, "both the leaders and the general public have more realistic information and attitudes about mental illness than shown by earlier studies".[38] Both the leaders and the residents felt that it is probably better to treat the mentally ill in the community, but that the ultimate success or failure of placing ex-patients back into the community is largely dependent upon the climate of opinion in the community.

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35. Irving Rootman, M. Phil, and H. LaFave, "Are Popular Attitudes Toward the Mentally Ill Changing?" American Journal of Psychiatry 126: 147-151, 1969.

36. Rootman, Ibid., p. 151.

37. J.W. Edgerton and W.K. Bentz, "Attitudes and Opinions of Rural People about Mental Illness and Program Services", American Journal of Public Health 59: 470-477, 1969.

38. W.K. Bentz and J.W. Edgerton, "Concensus on Attitudes Toward Mental Illness". Archives of General Psychiatry, 22: 468-473; and in W.K. Bentz and M. Kherlopian, "Perceptions of Mental Illness Among People in a Rural Area", Mental Hygiene 53: 459-465, 1969.

Research Since 1970

A general overview of the status of public attitudes toward mental illness and the mentally ill in the early 1970's seems to indicate that people are distinctly better informed and disposed toward mental patients than they have been, but that a "major portion of the population continues to be frightened and repelled by the notion of mental illness".[39]

Crocetti (1972) suggested that

> The public does not globally reject the mentally ill. On the contrary, the public does have hope for a favourable outcome to treatment for the patient, and accepts the proposition that this should be as near at home as possible.[40]

Studies in the 1970's continued to probe public attitudes toward the mentally ill in much the same fashion as previous research. With increasing deemphasis of psychiatric hospitalization, leading to the presence of increasing numbers of both acutely and chronically disturbed people in the community, the knowledge of community opinion and attitudes remains a vital issue in the successful rehabilitation of the ex-patient in the community. Researchers, however, continue to arrive at varying conclusions.

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39. Rabkin, 1974, p. 19.
40. Crocetti, Ibid., 1972, p. 2.

A Manitoba Mental Health Survey[41] carried out between June 1971 and February 1973 throughout the province, was designed to study knowledge of the nature of mental illness, knowledge of facilities and attitudes towards individuals treated at mental health facilities, and public attitudes toward the mentally ill. Areas in Manitoba were selected that had access to a mental health association. The results seemed to show varying attitudes. While most people said that they found the mentally ill easy to befriend, and would not be ashamed to marry a former patient, over 50% saw them as being dangerous[42], and almost half of the respondents felt that those who had been mentally ill should not be allowed to have children.[43] In general, women were found to be more tolerant and accepting. These findings reflect the general confusion and uncertainty that seems to dominate the public's response to mental illness -- and the formerly mentally ill.

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41. Manitoba Mental Health Survey, Mental Health/Manitoba. Canadian Mental Health Association, February 1973.

42. Jonas Rappeport and George Lassen, in "Dangerousness--Arrest Rate Comparisons of Discharged Patients and the General Population", American Journal of Psychiatry 121: 776-783, 1965; suggested as a result of his study, that dangerousness is usually measured by the rate of arrest. He found that aggravated assault offences in the discharged mentally ill are about equivalent to the rates of the general population. His findings suggested that there was no clear-cut indication that the mentally ill were to any great extent less involved in criminal behaviour than those in the general community, and that for some offences they were as involved as the general community, while for other offences such as robbery and also rape, the ex-patients were more frequently arrested than the general public. Whether the arrests resulted in convictions, or whether the former patients were more frequently suspected and consequently taken into custody for questioning, was not differentiated. It was also not mentioned how often the arrests resulted in actual convictions.

Bord (1971) repeated and extended the design used by Phillips (1963) using 350 college students enrolled in introductory sociology. He disagreed with Phillips' findings. Instead of finding that the source of help sought and the visibility of deviant behaviour were the major causes for rejection, he found that the major determinant of the degree of rejection on social distance items are the perceived unpredictability and danger of the behaviour in question.[44]

Farina (1971) looked at the effect of post-hospitalization on employability and interpersonal relations, using 60 male undergraduate students enrolled in psychology at the University of Connecticut.[45] The most significant finding of the study was that "believing an individual to be mentally ill strongly influences the perception of that individual".[46] Inspite of increased knowledge and awareness, ex-mental patients are simply not perceived with the same trust, good will, and restoration of the former "normal" status that is re-assigned to the ex-medical patient.

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44. B.J. Bord, "Rejection of the Mentally Ill: Continuities and Further Developments", Social Problems 18: 469-509, 1971.

45. A Farina and K. Ring, "The Influence of Perceived Mental Illness on Interpsonal Relations", Journal of Abnormal Psychology 70:48, 1971.

46. Ibid.

COMMUNITY RESPONSE TO SHELTERED CARE FACILITIES

With the movement of ex-patients into the community, a variety of housing arrangements and treatment programs have been developed to assist the discharged patient's re-entry and re-adjustment to community living. Evaluation of community attitudes is necessary to assess the community circumstances within which more negative and more positive attitudes toward the discharged mental hospital patient are found to prevail. Rabkin's (1974) survey of the literature led her to conclude that while candid rejection of the mentally ill seems to be less socially acceptable today, "discharged mental hospital patients are still regarded as undesirable companions, unreliable, immature, not really trustworthy, with a more or less chronic loss of status".[47] If this is so, then the question, which remains to be answered, is if the expression of more tolerant attitudes is equivalent to increased acceptance of the mentally ill persons in the community, in the home, and in the places where people work.

Aviram and Segal (1973) looked at the placing of discharged psychiatric patients into the community, and found some evidence to suggest that communites were developing new methods to exclude the mentally ill.[48] They suggested that

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47. Rabkin, 1974, p. 19.

48. Uri Aviram and S. Segal, "Exclusion of the Mentally Ill", Archives of General Psychiatry 29: 126-131, 1973.

physical existence in a certain community does not necessarily lead to social inclusion, and that community attitudes toward the housing of discharged psychiatric patients in the community have an important influence and effect on the successful integration of ex-patients to community living.

Lamb and Goertzel (1971) looked at a variety of housing arrangements for the ex-patient to ascertain if the patients living in them are "really in the community",[49] or if their living situation is simply like a small ward moved to a community setting. They concluded that the type of accomodation, and the expectations placed upon the ex-patient, determined to a large extent if the patient's residing in the community was in fact facilitating his reintegration into community living.[50] The less ex-patients were segregated, the higher the expectation of normalization that was placed upon them, the less likely he would be labelled as deviant, and the less stigmatization he would experience. All these factors would lead the patient to view himself as a functioning member of society and would also convey that message to the community in which he was placed. This raises the question of whether or not community attitudes are significantly related to the type of accomodation of the discharged patients, rather than with their deviation from

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49. H.R. Lamb and V. Goertzel, "Discharged Mental Patients--Are They Really in the Community?" Archives of General Psychiatry 24: 29-33, 1971.

50. Ibid.

socially acceptable behaviour. Since acceptance of the mental patient is facilitated by seeing him in a role that can be regarded as "normal",[51] perhaps housing him in accomodation which most closely resembles that of the majority in the community would be the most acceptable.

Spiro (1974) surveyed a blue collar population in Baltimore and showed that 59% of the study population reported knowing someone who had been hospitalized for mental illness, and that they failed to show any significant denial of contact with the mentally ill.[52]

Trute (1975) also suggested that community attitudes toward the housing of discharged mental hospital patients in the community, were important indicators of successful integration to community living.[53] His study of social indicators as predictors of social integration in a comparison between Saskatchewan and California, led him to comment that specific census tract areas may constitute "supportive communities in which special care facilities may be more productively placed".[54]

That community attitudes have an important bearing on the successful integration and re-adjustment of ex-patients to community living is a generally accepted fact. It is important

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51. Rabkin, Ibid., 1974, p. 18-32.

52. Herzl Spiro, Irad Siassi, Guido Crocetti, "The Issue of Contact with the Mentally Ill", American Journal of Public Health 64: 879-879, 1974.

53. B. Trute, "Social Indicators as Predictors of Social Integration in Saskatchewan and California", Doctoral Dissertation, University of California at Berkeley, 1975.

54. Ibid., 1975, p. 10.

for those responsible for the placement of patients into the community to be aware of what current attitudes are, what factors might cause attitudes to be more or less negative. If the community responds negatively, or reacts with hostility to certain types of housing for the ex-patient, then the patient has an extra burden to bear as he seeks to normalize within that community.

Recent comments in a Winnipeg newspaper suggest that attitudes of the public toward placing ex-patients within certain types of housing in the community are extremely negative. For example, in the August 26, 1975 edition of the Winnipeg Free Press it was reported that an attempt to establish a halfway house in the Polson-Charles Street area for the emotionally disturbed was defeated by residents, backed by their community counsellors. The community fears that moving those with mental problems into the area would add to existing problems were supported by one counsellor who commented that "even a doubled police force couldn't handle the problems that would arise". Similarily, the same paper on September 16, 1976 carried an article on complaints by Wolseley area residents concerning halfway homes in their area "resulting in an increasing degeneration of the area". During the recent by-election in that area, some concern was expressed that the area was becoming a "dumping ground" for deviant groups. These, and similar concerns expressed by the public, have an important bearing on the

placement of discharged mental hospital patients within the community. If the resistance of the community to the acceptance and integration of the discharged patients varies with, or is affected by, the type of housing in which the ex-patient is placed, then it is imperative that those responsible for the housing of discharged patients be aware of it and take appropriate action.

The successful social integration of the mentally ill may be partially dependent on the nature of community attitudes, and these different attitudes may be expressed in response to the type of housing facility. Different communities may also vary in how they relate to those defined by them as deviant, and express different degrees of social tolerance of someone exhibiting unusual or unpredictable behaviour.

SUMMARY OF FINDINGS

Although the literature on attitudes towards the mentally ill tends to be somewhat equivocal, the predominant theme since 1960 has suggested that attitudes toward the mentally ill have become more "positive". Using the Cumming's 1951 study as a baseline, studies in attitudinal social distance since that time have suggested changes in attitudes to an increasing acceptance of the former mentally ill. Some studies, however, report no significant changes in attitude, or more rejecting attitudes. Analysis of standard social distance items reported in the

various studies, suggest that there is a common trend toward more tolerant attitudes, but that there is a wide variation in the degree of change. An overall view suggests that there is increasing public acceptance in verbally expressed attitudinal social distance towards the discharged psychiatric hospital patient.

FACTORS AFFECTING PUBLIC ATTITUDES

The review of the literature indicated that studies of attitudes have suggested a number of factors which affect public response toward the discharged psychiatric patient. Although the focus of this study is on the effect of patient housing on community attitudes, it is worthwhile to consider other factors which have been found to affect attitudes the general public has toward the formerly mentally ill.

> Attitudes are determined, to some extent, by the degree of unpredictability and loss of accountability, the personal characteristics of the persons manifesting the behaviour, the particular symptoms the diagnostic category involved, the visibility of the disturbed behaviour, and the extent to which violence is an issue.[55]

The major factor accounting for rejection, attributed exclusively to mental patients, is their lack of predictability

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55. Rabkin, Ibid., 1974, p. 19.

(Cumming and Cumming 1965;[56] Nunnaly 1961; and Bord 1971). As Nunnally pointed out, "because unpredictable behaviour is frightening and disruptive, much societal machinery is devoted to making the behaviour of individuals predictable to others".[57]

Social class has long been seen as a determinant of public tolerance (Redlich, 1956).[58] The lower the social status of the deviant person, the more likely is his rejection from the community (Goffman 1961;[59] and Bord 1971).

The more socially visible the disturbed behaviour is, the more the public tends to reject it, whether or not the behaviour has severe incapacitating effects on the person (Lemkau and Crocetti 1961; Phillips 1964; and Rabkin 1972). Males are also more heavily stigmatized and hence more rejected than are females (Phillips 1964).

One of the most consistent findings throughout the review of the literature is the relationship between age and education. The older and less educated the individual, the more intolerant, rejecting, and distant are his attitudes toward the mentally ill (Ramsay and Seipp 1948; Woodward 1951; Cumming and Cumming 1955; Whately 1959; Phillips 1964; Crocetti and Lemkau 1963; and Dohrenwend and Chin-Shong 1967).

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56. John Cumming and E. Cumming, "On the Stigma of Mental Illness", Community Mental Health Journal Vol. 1, No. 2, 1965, pp. 135-143.

57. Nunnally, Ibid, 1961, p. 46.

58. F.C. Redlich, A.B. Hollinshead, E. Bellis, "Social Class Differences in Attitudes Toward Psychiatry", American Journal of Orthopsychiatry 25: 60-70, 1955.

59. E. Goffman, Asylums (Englewood Cliffs, New Jersey: Prentice-Hall, 1963).

Experience with a psychiatric patient and expressed social distance has resulted in no consistent correlation. Whateley (1959) suggested that experience with a psychiatric patient did not reduce social distance. On the other hand, experience was seen as reducing social distance if a friend were mentally ill (Phillips 1964; Spiro 1974); and as increasing social distance if the ill person were a relative (Phillips 1964). Spiro (1974) suggested that acquaintance with an out-patient did not lead to greater acceptance, but that a close tie with an ex-patient did.

RELATIONSHIP BETWEEN ATTITUDES AND BEHAVIOUR

Some research has been done on the relationship between verbally expressed attitudes and actual behaviour. In spite of the fact that attitudes and behaviour have not always proved consistent, researchers in the last twenty-five years have felt that the impact of community attitudes on the successful reintegration of the discharged mental hospital patient were sufficient to warrant extensive studies. Also, if certain factors evoke more negative responses than others, it is important to ascertain which factors those are, and to remedy them if possible.

In general, the public does seem to have a basically negative stereotype of the mental patient (Sarbin 1972; Rabkin

1972; and Page 1974[60]). However, it has been found that although people may express negative attitudes about the mentally ill, they are usually fair and generous in actual dealings with them.[61]

In LaPiere's (1934) study of the relationship between verbally expressed attitudes and actual behaviour, he found an almost inverse correlation between the two.[62] Rabkin (1974), in her review of the literature, suggested that situational and personal factors could detract from the strength of that inverse relationship.

Bord (1971) observed that people may express good will toward mental patients to a researcher, but may oppose the presence of a halfway house for them in his community in the anonymity of a voting booth. These findings suggest that people often express attitudes and opinions that are "socially acceptable" or desirable, but which differ from actual behaviour.

Halpert (1969) suggested measuring the relationship between attitudes and behaviour on the basis of the public's help-seeking behaviour for emotional problems. He felt that if people had an "enlightened" attitude towards those with mental problems, their approach to seeking help would also be more

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60. Stewart Page, "The Elusive Character of Psychiatric Stigma", Canada's Mental Health, June 1974, Vol. 22, No. 2, pp. 15-17.

61. S. Olshansky, "Community Aspects of Rehabilitation". In M. Greenblat and M. Simons (Eds.), The Rehabilitation of the Mentally Ill (American Association for the Advancement of Science, 1959), pp. 312-322.

62. R.T. LaPiere, "Attitudes Vs. Actions", Social Forces 13: 230-237, 1934.

enlightened. On the basis of his research, he found that this was not the case.[63] People's behaviour concerning their own need for help with mental or emotional problems did not correlate significantly with their attitudes towards others with similar problems.

LaFave and Rootman (1967) compared attitudes and behaviour in two Canadian towns. They found that community behaviour toward the mentally ill was not what they would have predicted on the basis of the attitudes as measured by a survey.[64] In fact, they found that the more "enlightened" and "sophisticated" community manifested less tolerant behaviour toward its mentally ill. This was demonstrated by the fact that over one-third of the adult population signed a petition to reject the establishment of a halfway house for former patients in their community. In contrast, the residents of the "unenlightened" town were the most cooperative in the establishment and operation of foster homes for former patients.

COMMUNITY RESPONSE AS A FUNCTION OF TYPE OF RESIDENCE

Whereas no previous research has focused specifically on the effect of patient housing on the attitudes of the community,

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63. Halpert, Ibid., 1968, p. 62.

64. H.G. LaFave, I. Rootman, D. Sydiaha, and R. Duckworth, "The Ethnic Community and the Definition of Mental Illness: A Comparative Study of French and Non-French Canadian Towns", Psychiatric Quarterly 41: 211-227, 1967.

it would appear from the review of the literature that community attitudes toward certain types of accomodation, especially the larger board and care homes, are essentially negative.

If certain types of housing arouse a more rejecting and less tolerant response in the local community, then placing a discharged patient into that type of housing could seriously hinder and prevent his successful re-entry to community living. While other factors may also be responsible in part, it is important to study the effect of patient housing on the attitudes of the community in which discharged patients are placed.

CHAPTER III

METHODOLOGY

The sample for the study was determined by the location of after-care facilities utilized by a patient discharged from the Selkirk Mental Health Centre. A questionnaire was administered by researchers in the respondent's home during a two month period extending from December 9, 1975 to February 9, 1976.

SAMPLING PROCEDURES

To compare attitudes to the type of housing, a list was compiled of various types of housing available to discharged mental hospital patients (i.e. foster homes, board and care homes, and group homes for independent living).

The homes were grouped into three strata, according to the number of beds available in the facility to persons who had been discharged from the Selkirk Centre, and were presently residing in the community. A fourth strata included all nine units of the Independent Group Homes. The four strata of housing types established for the sample were:

Strata I - 1 resident
Strata II - 2-3 residents
Strata III - over 4 residents
Strata IV - Independent Group Homes

The sample was then drawn using systematic random sampling. From Strata I, eighteen units (or 36.7%) were selected. Nine units in each of Strata II (28.1%) and Strata III (45.0%) were selected, and all nine Independent Group Homes (100%) were used. This provided a total of 45 housing units to be included in the study.

Using random systematic sampling neighborhood houses on both sides of the same street were selected in the community where each of the above housing type was located. For Strata I, one neighborhood house was selected on the same street as each after-care facility, for a total of 18 community homes. For each facility in the other three strata, two neighborhood houses on both sides of the same street were selected to be included in the study. One resident, between the ages of 18 and 65 years was then selected at random from each community house. This provided a total of 72 community residents to be included in the sample.

Because of the limits of time and finances, we were not able to do a systematic sample of the entire city. We went into only those areas where an after-care facility for the discharged psychiatric hospital patient was already located. The findings may therefore reflect the attitudes of only those neighborhoods with homes for discharged mental hospital patients in them.

QUESTIONNAIRE CONSTRUCTION

A questionnaire was developed to obtain demographic data and to elicit responses to statements about mental illness and

the mentally ill. Demographic data was obtained which included age, sex, marital status, educational attainment, religious preference, ethnic identification, income level, mobility, household composition, number of children, and the respondent's perception of his area of residence.

A short experience scale was constructed to measure levels of experience with discharged psychiatric patients. The items formed a natural Guttman scale with a coefficient of reproducibility of 0.90 and a coefficient of scalability of 0.72. (See Appendix A for the items used in the scale.)

The questionnaire used a Likert-type scale to examine the public opinions towards discharged mental hospital patients in response to general statements about the mentally ill. Statements used in this study were similar to ones used by Cumming and Cumming (1956), Nunnally (1961), Lemkau and Crocetti (1962), Meyer (1964), Dohrenwend and Chin-Shong (1967), Rootman (1969), Edgerton and Bentz (1969), Manitoba Mental Health Survey (1973), and Spiro (1974). A list of these statements is found in the questionnaire in Appendix B.

Community reaction to the different types of after-care facilities for the discharged psychiatric patient will be considered in terms of the visibility of the housing type.

A social distance scale was used in the study to measure the extent to which the public accepts or rejects social intimacy with the former patient. Similar items to the ones used by Cumming and Cumming (1957), and later used by Lemkau and Crocetti (1962), Meyer (1964), Dohrenwend and Chin-Shong (1967),

Rootman (1969), Phillips (1962, 1966), Crocetti (1963), and Bord (1971), were used with the addition of several different items. The items tested are listed in Appendix A. Seven items emerged to form a natural Guttman scale (coefficient of reproducibility 0.90 and coefficient of scalability 0.62).

Vignettes of case descriptions of mentally ill persons were used to examine public opinions to more specific descriptions of mental illness. The case descriptions, developed by Star (1951), included a paranoid schizophrenic, a simple schizophrenic, a phobic compulsive, an alcoholic, a behaviour disorder, and an anxiety neurotic. A description of a normal person, developed by Phillips (1962) was also used.

Finally, the questionnaire also included the Marlowe-Crowne Social Desirability Scale[65] to test the need of the subjects to respond in culturally sanctioned or socially acceptable manner.

QUESTIONNAIRE ADMINISTRATION

The questionnaire was pre-tested on a group of undergraduate students (N=30) at the University of Manitoba in mid-October, Ambiguous items were revised.

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66. Douglas P. Crowne and David Marlowe, "A New Scale of Social Desirability Independent of Psychopathology", Journal of Consulting Psychology 1960, Vol. 24, No. 4, 349-354.

A split-half reliability test was done with 44 attitude variables. The resulting correlation of 0.96 was significant at the 0.001 level.

A significance level of .10 will be used in this study. Findings will also be discussed which do not reach the .10 level of significance, but which are in the direction predicted.

The final questionnaire took approximately 40 minutes to administer and was conducted on a face-to-face basis in a standardized interview in the respondent's home.

CHAPTER IV

RESULTS AND DISCUSSION

SAMPLE DESCRIPTION: DEMOGRAPHIC CHARACTERISTICS

The sample chosen consisted of 72 "normal" community residents. Only 62 were interviewed, since two could not be located at the addresses given, one refused because of a recent death in the family, and seven others refused to grant an interview because they "weren't interested" or because they "couldn't be bothered".

The sample was composed of 34 females (54.8%) and 28 males (45.2%). The ages were evenly distributed between 18 and 65 years. Table summarizes the age and sex distribution of the respondents.

TABLE I: DISTRIBUTION OF RESPONDENTS BY AGE AND SEX

AGE	MALE	FEMALE	TOTAL	PERCENTAGE
18-28	5	3	8	12.9
29-38	7	11	18	29.0
39-48	6	6	12	19.4
48-58	5	4	9	14.5
59-65	5	10	15	24.2

One-third of the sample (33.9%) were under 35 years, one-third between 36 and 53 years, and one-third were 54 years or older. The average age of the sample population was 44.1 years, with a standard deviation of 14.28.

Table II illustrates the distribution of respondents by marital status and sex.

TABLE II: DISTRIBUTION OF RESPONDENTS BY MARITAL STATUS AND SEX

MARITAL	MALE	FEMALE	TOTAL	PERCENTAGE
Single	5	4	9	14.5
Married	21	22	43	69.4
Widowed	0	4	4	6.5
Separated	0	1	1	1.6
Divorced	0	2	2	3.2
Common Law	2	1	3	4.8

Most of the respondents (69.4%) were married. Only a minority (14.5%) were single people who had never married.

Table III illustrates the distribution of the levels of education achieved by the respondents in the sample population. Approximately one-third (39.3%) of the sample population had a complete high school education or better. However, one-half (60.7%) of the respondents had less than a high school education.

TABLE III: DISTRIBUTION OF RESPONDENTS BY EDUCATION

EDUCATION	PERCENTAGE OF RESPONDENTS
No Education	3.3
Some Grade School	6.6
Complete Grade School	19.7
Some High School	31.1
Complete High School	8.2
Some Vocational School	1.6
Complete Vocational School	11.5
Some University	13.1
Completed University Degree	4.9

Table IV shows that the religious preference of the respondents was categorized into three broad categories: Catholic, Jewish, and Protestant. Forty percent (40.3%) of the respondents were Catholic and 46.8% were Protestant.

TABLE IV: DISTRIBUTION OF RESPONDENTS BY RELIGIOUS PREFERENCE

RELIGION	PERCENTAGE OF RESPONDENTS
Catholic	40.3
Jewish	3.2
Protestant	46.8
Other	1.6
None	8.1

The two largest ethnic groupings in our sample population were German (29.0%) and Ukranian and Polish (16.1%). This may suggest that our sample population was over-represented by those ethnic groupings, or that the neighborhoods in which discharged psychiatric patients are housed are ethnically a-typical.

TABLE V: DISTRIBUTION OF RESPONDENTS BY ETHNIC ORIGIN

ETHNIC ORIGIN	PERCENTAGE OF RESPONDENTS
Ukranian/Polish	16.1
British/Scottish/Irish	9.7
Scandinavian	1.6
French	9.7
German	29.0
Other European	6.5
Asian	3.2
Italian	4.8
Portuguese	4.8
Other/None	14.5

The demographic characteristics have been reviewed to indicate the type of neighborhoods our sample population represents. The demographic characteristics of our sample population in the various strata of housing types did not differ significantly. Also, when attitudes and community acceptance were considered in regard to their relationship to demographic factors, it was found that there was no significant relationship between any of the demographic factors and the social distance scale and the community housing scale.

SAMPLE DESCRIPTION: SOCIO-ECONOMIC CHARACTERISTICS

Three-quarters (78.0%) of the sample population had a total household income of less than $15,000; 58.0% of the respondents had a total household income which fell into the $5,000 to $15,000 range. Fifteen percent (14.5%) reported incomes of less than $5,000. Forty-five percent (45.1%) of the study population had incomes which were below $10,000.

TABLE VI: DISTRIBUTION OF RESPONDENTS BY INCOME

INCOME	PERCENTAGE OF RESPONDENTS
Under $5,000	14.5
$5,001 - 10,000	30.6
$10,001 - 15,000	27.4
$15,001 - 20,000	14.5
$20,001 - 25,000	1.6
$25,001 - 30,000	4.8
Refused to answer	6.4

Fifty-three percent (53.2%) of the sample population were working at a job outside of the house. Of the men who were working (71.4%), all were working at full-time jobs. Thirty-eight percent (38.2%) of the females were working, 61.6% of them full-time. The majority of those working had been at their jobs for two years or more. Most of the respondents were occupied in a trade or as a laborer.

Table VII illustrates the distribution of respondents in our sample population by sex and by the type of job they were working in.

TABLE VII: DISTRIBUTION OF RESPONDENTS BY SEX AND TYPE OF JOB

TYPE OF JOB	MALE	FEMALE	PERCENTAGE
Business	14.3	0.0	6.5
Professional	3.5	8.8	6.5
Clerical	0.0	17.6	9.7
Other White Collar	7.1	0.0	3.2
Trade	17.9	2.9	9.7
Laborer	25.0	2.9	12.9
Construction	3.6	0.0	1.6
Other	0.0	5.8	3.2
Not Working	28.6	61.8	46.8

The households of the selected sample had an average of 3.6 people per household, with a standard deviation of 1.75. Half of the homes (51.6%) had children living in them.

In terms of geographic mobility, the study population was fairly stable. Fifty percent (50.0%) of the sample had lived in their neighborhood for eleven years or more.

The average length of stay in the area was 144.4 months (12 years), with a standard deviation of 113.2 months (9.6

years). Sixty-one percent (61.3%) of the sample population had lived in the same place for the past five years, with eighty-seven percent (87.1%) having lived in two places or less.

Most of the respondents (62.9%) saw themselves as belonging to the working class. Fifty-nine percent (59.9%) of the sample population said that their neighborhoods were friendly, and an additional 38.7% said that they were "about average", in terms of friendliness.

The respondents were asked several questions to demonstrate the level of social interaction that was considered to be the norm within the sampled neighborhoods.

One-quarter (22.6%) of the study population said that they didn't know any of their neighbors, whereas another 24.2% said that they knew seven or more. The remaining fifty percent of the study population reported knowing an average of three to four neighbors "other than just to say hello to".

Ninety percent (90.3%) of the study population said that they were satisfied living in their area.

The socio-economic characteristics of the sample population have been demonstrated to indicate the income levels and the level of social interaction which is considered to be the norm in the sampled neighborhoods. It was found that the income levels and the level of social interaction in the various strata of housing types did not differ significantly. Also, there was no significant relationship between the socio-economic factors

and the social distance scale and the community housing scale. However, since many of the discharged psychiatric patients are on some form of social assistance, and may or may not be working, their placement into neighborhoods with a high socio-economic standard may affect their reintegration to community living.

LEVELS OF EXPERIENCE WITH DISCHARGED PSYCHIATRIC PATIENTS

Natural Guttman scaling occurred regarding the respondent's levels of experience in having direct, "face to face", contact with someone identified as a "psychiatric patient". The items in the scale included, in order of Guttman Rank:

1. Have you ever known anyone who has been a patient in a psychiatric hospital? (Yes=1; No=0).
2. To your knowledge, have you ever worked with someone who has been a patient in a psychiatric hospital?
3. Have any of your close friends ever been a patient in a psychiatric hospital?
4. Have you ever visited a patient in a psychiatric hospital?

The coefficient of reproducibility was 0.90, and the coefficient of scalability was 0.72.

The most basic level of experience was knowledge of someone who had spent time in a mental hospital. The respondent's level of experience was considered to increase if he had worked with a former patient, and further, if the respondent previously

had a close friend who had been a patient in a psychiatric hospital. The highest level of experience was said to occur when the respondent had visited a patient in a psychiatric hospital.

The experience scale is a uni-dimensional and cummulative scale in that it measures the quantity of experience with former psychiatric patients. The scale may also suggest, however, that it measures a quality of experience, since the entire scale seems to build toward more intimacy in the relationships.

Table VIII illustrates the mean experience scores of respondents near the various types of after-care facilities, where 0 represents no experience with ex-patients, and 4 represents experience on all four levels as indicated by the experience scale.

TABLE VIII: MEAN EXPERIENCE SCORE OF RESPONDENTS BY RESIDENCE TYPE

	RESIDENCE TYPE			
	1 PERSON	2-3 PERSONS	OVER 4 PERSONS	INDEPENDENT GROUP HOMES
MEAN EXPERIENCE SCORE	1.50	2.00	1.46	2.14
S.D.	1.36	1.41	1.59	1.46
N.	16	16	15	14

(Means not significantly different)

Using a T-test it was found that level of experience with the mentally ill was constant across all strata, and therefore would not confound the study of attitudes towards discharged psychiatric patients as a function of housing.

HOUSING IMPACT: DIFFERENCES IN VISIBILITY

When comparing community reaction to the different types of housing for the discharged patient, we found that there was a difference in visibility of the different types of housing ($x^2 = 10.60$, df = 3, $p<.01$).

TABLE IX: PERCENTAGE OF RESPONDENTS AWARE OF DISCHARGED PATIENTS LIVING IN THE COMMUNITY BY HOUSING TYPE

	YES	NO
STRATA I: Homes with one former patient	12.5	87.5
STRATA II: Homes with 2-3 former patients	25.0	75.0
STRATA III: Homes with over 4 discharged patients	53.3	46.7
STRATA IV: Independent Group Homes	6.7	93.3

Over half (53.3%) of the study population living in areas of the large board and care homes (Strata III) could identify houses in which discharged patients lived in their neighborhood.

Community awareness of discharged psychiatric patients being housed in the neighborhood decreased, as the number of ex-mental patients being housed in a single unit decreased. Twenty-five percent (25.0%) of the study population near homes with 2-3 former patients were aware of discharged patients living in the area. When one former patient was living with a family in the community, only 12.5% of the community residents reported knowing about it.

When former patients lived together in Independent Group Homes within the community, they were less obvious as being "mentally ill". Only 6.7% of our sample population living near the Independent Group Homes said that they were aware of discharged psychiatric patients living in their neighborhood.

The differences in visibility of discharged psychiatric patients, in the context of the type of housing, may suggest that patients living together in Independent Group Homes are more likely to be regarded as "normal", and hence afforded the normal status in the community.

HOUSING IMPACT: COMMUNITY REACTION TO TYPE OF HOUSING

In terms of community reaction, we found that different types of housing for the mentally ill had a different impact on the reaction by their neighbors. Attitudes toward housing for the mentally ill in the community (Community Housing Scale) formed a natural Guttman Scale (with a coefficient of

reproducibility of 0.92 and a coefficient of scalability of 0.75) indicating that the scale met acceptable standards in that it formed a uni-dimensional and cummulative scale.

The Community Housing Scale was made up of the following items (in order of Guttman Rank):

1. If a family in your community took a former psychiatric patient into their home as a boarder, the patient would be excluded from taking part in the community. (Agree=1; Disagree= ; Undecided=0).

2. If 3-4 discharged psychiatric patients rented an apartment or house in your neighborhood, they would be accepted to take part in the community.

3. The people in your community would not be opposed if someone on your street took in 2-3 discharged patients as boarders.

4. Your community would agree to a halfway house for former psychiatric patients being opened in your neighborhood.

In forming the Guttman scale, it was found that the public was least resistant to a family taking a single patient into their home as a boarder. The scale also indicated that community attitudes are more favourable toward 3-4 discharged patients renting an apartment or house in the neighborhood, than they are toward a family taking 2-3 ex-patients as boarders.

Least acceptable for the community resident was a halfway house for the former patients. The respondents expressed some fear and concern about the larger number of patients being housed together in the community, and questioned their ability to live outside of the hospital setting.

When considering community housing for the post-hospital psychiatric patient, community residents were more in favour of having one ex-patient living in a foster home within the community and of 3-4 discharged patients living togehter in independent housing. Forty-nine percent (49.2%) of the study population were accepting of a discharged psychiatric patient living in the community with a foster family, or independently with a group of 3-4 former patients.

Community acceptance of the foster home arrangement for former patients may suggest that it is more acceptable to neighbors, since it is more like the normal family within the community. Acceptance of 3-4 discharged patients living together in independent housing, may be because that type of living arrangement for former patients suggests to community residents that the former patients are not sick to the degree that they cannot look after themselves.

A further thirty-six percent (36.1%) of the study population were accepting 2-3 former patients living in private homes as boarders. Only fourteen percent (14.8%) of our sample population were accepting of a halfway home for discharged psychiatric patients being opened in their neighborhood.

In our interviews with the community residents, the respondents suggested that the larger board and care homes and halfway homes served primarily a custodial function, and as such were not welcome in the neighborhood.

The data concerning community reaction to the type of sheltered care facility, suggests that community residents are more tolerant of housing for ex-mental patients if the number of persons housed in a single unit is low, and/or if the discharged patient is living in a situation which most closely resembles that of a normal household such as in the Independent Group Homes.

This finding supports the use of single placements and the placement of 3-4 discharged patients in independent group homes, and may well coincide with patient need--the chronic patient needing the long-term care and supervision provided by foster family care, and the acute patient requiring only the supervision provided in the independent group homes.

The data also suggests that community respondents living in neighborhoods of the foster homes and the Independent Group Homes, not only express more tolerant attitudes toward the mentally ill, but are also more accepting of all types of community housing for the former patient.

A test of differences between respondents living in proximity to the different types of sheltered housing for the discharged patient, showed that community residents living near foster homes with one former patient, were significantly ($T=2.74$, $df=29$, $p<.06$) more accepting of foster home care for the mentally ill than were respondents living near the large board and care homes.

In addition, respondents living near the foster homes were also significantly ($T=3.20$, $df=30$, $p<.03$) more willing to accept a halfway house being opened in their neighborhood than were respondents living in neighborhoods with small board and care homes with 2-3 ex-patients.

Community residents living in neighborhoods of the Independent Group Homes were significantly ($T=3.96$, $df=28$, $p<.01$) more accepting of halfway homes being opened in the community than were the respondents living near the small board and care homes with 2-3 former patients living in them.

The findings suggest that community residents are more accepting of foster care and independent group living for the mentally ill. Community residents, living in areas where there are foster homes and Independent Group Homes, are more accepting of community based after-care facilities for the former patients, than are respondents living near other kinds of housing.

COMMUNITY REACTION: SOCIAL DISTANCE ITEMS

A social distance scale was used to measure the extent to which the respondent rejects social intimacy with the discharged psychiatric patient.

Seven items emerged to form a Guttman Scale (coefficient of reproducibility of 0.90, and coefficient of scalability 0.62).

The items used to form the scale were, in rank of degree of social distance:

1. You would be willing to work on the same job with someone who had been a patient in a psychiatric hospital. (agree)

2. You would welcome someone who had spent time in a psychiatric hospital to take part in your community functions. (agree)

3. If you were a manager and were responsible for hiring people to work for you, you would be willing to hire a discharged psychiatric patient. (agree)

4. It would be unwise to encourage the close friendship of someone who had been in a psychiatric hospital. (disagree)

5. If the house next door was for sale, you would object to someone with a history of psychiatric problems buying it. (disagree)

6. You would not resent the presence of a residence for discharged psychiatric patients in your area. (agree)

7. You would strongly discourage your children from marrying someone who had been a patient in a psychiatric hospital. (disagree)

The social distance scale represented the order of "closeness" the respondents were willing to tolerate with a former mental hospital patient. Fifty-four percent (54.0%) of the respondents expressed a willingness to work on the same job with someone who had been a patient in a mental hospital. Fifty-one percent (51.0%) of the respondents were willing to welcome former patients at community functions, while 49.0% of the community residents said that they would be willing to hire a former patient. Forty-six percent (46.0%) of the study population said that the former patient was acceptable as a close

friend. Forty-two percent (42.0%) of the study population said that they would not object to having a neighbor with a history of psychiatric problems. Thirty-nine percent (39.0%) of the community residents said that they would not resent a residence for discharged psychiatric patients in the neighborhood. The relationship least well tolerated was that of having the discharged patient as a prospective mate for the respondent's children. Only 21.0% of the study population said that they would tolerate such a close relationship.

It was interesting to note that it was less acceptable to have a residence for discharged psychiatric patients in the community, than it was for the respondents to have a next door neighbor with a history of psychiatric problems. This may suggest that a "residence for discharged patients" has more negative connotations, perhaps because of the larger number of persons living in such a facility, and the implication that the ex-patients living there are not capable of living on their own. This conclusion would be consistent with the previously mentioned findings that community reaction to the housing of discharged patients in the neighborhood is less negative if the former patients are living on their own in a setting more consistent with what is considered "normal", than when a number of patients are housed together in one facility.

COMMUNITY HOUSING: REACTION TO SOCIAL DISTANCE ITEMS

The population studied expressed greater or lesser social distance as a function of their residing on the same city block as a certain type of after-care facility.

TABLE X: MEAN SCORES ON SOCIAL DISTANCE ITEMS BY RESIDENCE TYPE

	RESIDENCE TYPE			
	1 PATIENT	2-3 PATIENT	OVER 4 PATIENTS	INDEPENDENT GROUP HOMES
MEAN SOCIAL DISTANCE SCORE	4.50	4.43	5.20	5.78
S.D.	2.00	2.42	1.82	1.84
N.	16	16	15	14

The table illustrates the mean scores on the social distance items, where 0 represents total rejection, and 7 total acceptance on all items.

A comparison of the mean scores on the social distance scale, suggests that respondents living in areas of the Independent Group Homes (Strata IV) are significantly ($T=1.17$, $df=28$, $p<.07$) more willing to accept more intimate relationships with former patients than are the respondents living near family foster homes (Strata I).

The community residents in our sample population living in areas where families have 2-3 former patients in their homes

as boarders, are significantly more resistant to accepting contact with former patients on social distance items than are the respondents living near the Independent Group Homes ($T=1.72$, $df=28$, $p<.09$).

For the overall mean social distance score, the respondents living near the large board and care homes did not differ significantly from respondents living near other types of after-care facilities, a finding that was inconsistent with all other results. Although the respondents living in areas of the Independent Group Homes scored higher on the social distance items than did the respondents living near the large board and care homes, and the direction was in the trend predicted, the difference was not significant.

Respondents in our sample population, living in neighborhoods of the Independent Group Homes, were significantly more willing to have a next door neighbor with a history of psychiatric problems, than were respondents living near foster homes ($T=2.69$, $df=28$, $p<.01$), near the small board and care homes with 2-3 former patients ($T=2.32$, $df=28$, $p<.02$), or respondents living near the large board and care homes ($T=1.74$, $df=27$, $p<.09$).

Neighbors of the Independent Group Homes in our sample population, tended to be consistently more accepting in their attitudes on social distance items, than were respondents living near other kinds of after-care facilities.

COMMUNITY REACTION: RESPONSE TO GENERAL ATTITUDE STATEMENTS

When considering the general attitude statements, several items emerged that suggested different attitudes of community residents, depending on their proximity to certain kinds of after-care facilities. The findings suggest that general community attitudes in relation to certain beliefs about the mentally ill may be a function of housing.

The items which emerged that indicated significant differences in attitudes between the various strata of housing types were:

1. You would not resent the presence of a residence for discharged psychiatric hospital patients in your area.
2. Persons who are or have been in a psychiatric hospital are easy to tell from normal people.
3. Most discharged psychiatric hospital patients are willing to work.
4. You can imagine yourself falling in love with someone who had been a patient in a psychiatric hospital.
5. Even though people who had been discharged from a psychiatric hospital may seem all right, they should not be allowed to marry.
6. It is foolish for a woman/man to marry a man/woman who has had a severe psychiatric illness, even though he seems fully recovered.
7. A person who has been a patient in a psychiatric hospital is more dangerous than the general population.

(A) QUESTION: You would not resent the presence of a residence for discharged psychiatric hospital patients in your area.

Eighty-five percent (85.7%) of the sample population living in areas of the Independent Group Homes said that they would not resent the presence of a residence for discharged psychiatric patients in their area. Sixty-two percent (62.5%) of the respondents living near the smaller board and care homes, with two to three ex-patients, agreed to not feeling resentment should a residence be located in their area. Fifty percent (50.0%) of the community residents in areas where a family had taken an ex-patient into their home as a boarder, said that they would not resent a residence for former patients being located in their neighborhood.

In a test of difference between respondents near the various types of after-care facilities for the mentally ill, it showed that community residents living near the Independent Group Homes were significantly ($T=1.86$, $df=28$, $p<.07$) more accepting of a residence for discharged psychiatric patients than are the respondents living near foster homes for ex-mental hospital patients.

In our interviews with the community residents, several of the respondents living near the large board and care homes (Strata III), who reported knowing of discharged patients living in the area, said that they resented the presence of a large after-care facility for former mental hospital patients in their area, but that there was not much that they could do about it.

(B) QUESTION: Persons who are or have been in a psychiatric hospital are easy to tell from normal people.

It was interesting to note that none of the community residents living near the Independent Group Homes felt that persons who are or have been in a psychiatric hospital are easy to tell from normal people. Thirty-one percent (31.3%) of the respondents living near foster homes with one ex-mental hospital patient, felt that discharged patients were easy to recognize. Of the respondents living near the other types of sheltered facilities, 26.7% near the large board and care homes, and only 12.5% near the smaller board and care homes (2-3 residents), felt that ex-mental patients were easy to recognize.

Respondents living near the Independent Group Homes felt that discharged patients were significantly ($T=3.03$, $df=28$, $p<.005$) more difficult to recognize than did the respondents living near foster homes for former patients. Community residents living near the Independent Group Homes also found the former patients significantly more difficult to recognize than either the respondents near the small board and care homes (Strata II)($T=2.89$, $df=28$, $p<.06$), or the respondents near the large board and care homes ($T=2.20$, $df=27$, $p<.03$).

(C) QUESTION: Most discharged psychiatric hospital patients are willing to work.

There was a significant difference ($X^2=21.0$, $df=9$, $p<.01$) between the types of housing and attitude responses to the statement that "most discharged psychiatric hospital patients are willing to work".

TABLE XI: PERCENTAGE OF RESPONDENTS REPLYING TO THE STATEMENT THAT MOST DISCHARGED PSYCHIATRIC PATIENTS ARE WILLING TO WORK BY RESIDENCE TYPE

	MOST DISCHARGED PYSCHIATRIC PATIENTS ARE WILLING TO WORK.		
	AGREE	UNDECIDED	DISAGREE
STRATA I	87.6	12.5	0.0
STRATA II	68.8	31.3	0.0
STRATA III	53.3	13.3	33.3
STRATA IV	84.6	15.4	0.0

Except for the respondents living in the area of the large board and care homes (Strata III), almost all of the community residents felt that discharged psychiatric patients are willing to work.

A test of difference between the respondents living near the various types of after-care facilities indicated that the respondents living near the foster homes with one former patient felt that discharged patients were significantly more willing to work than did the respondents living near the large board and care homes ($T=-2.79$, $df=29$, $p<.009$). Further, respondents living near the Independent Group Homes felt that discharged patients were significantly more willing to work than did respondents living near the small board and care homes ($T=2.84$, $df=27$, $p<.07$).

Community residents living near the larger board and care homes (Strata III) felt that former patients were significantly less willing to work, than did respondents living near the small board and care homes with only 2-3 ex-patients ($T=3.86$, $df=29$, $p<.01$), or than those living near the Independent Group Homes ($T=6.28$, $df=26$, $p<.003$).

The findings suggest that community residents living near the foster homes and the Independent Group Homes tend to view the former patient as significantly more willing to work than do respondents living near other kinds of sheltered housing for the discharged patient. This view of the former patient is congruent with normal expectations placed on community residents, and supports the hypothesis that ex-patients in housing that approximates that of the rest of the community, tend to be regarded as "normal" by the community residents, and have "normal" expectations placed on them.

(D) QUESTION: You can imagine yourself falling in love with someone who had been a patient in a psychiatric hospital.

There was a significant difference ($X^2=20.00$, $df=9$, $p<.01$) between community residents in the various strata of housing type and their response to the statement "You can imagine yourself falling in love with someone who has been a patient in a psychiatric hospital".

Almost all (84.6%) of the community respondents living near the Independent Group Homes (Strata IV) said that they

could imagine such a close relationship with a former mental patient, whereas less than half of the respondents near other types of after-care facilities could see themselves in such a relationship. Respondents living near the Independent Group Homes were significantly more accepting of such a relationship, than were neighbors of foster homes ($T=4.37$, $df=27$, $p<.000$), of small board and care homes with 2-3 former patients ($T=2.86$, $df=28$, $p<.07$), or of the large board and care homes ($T=3.09$, $df-26$, $p<.005$).

TABLE XII: PERCENTAGE OF RESPONDENTS ABLE TO IMAGINE THEMSELVES FALLING IN LOVE WITH A FORMER PSYCHIATRIC PATIENT BY RESIDENCE TYPE

	RESPONDENTS ABLE TO IMAGINE THEMSELVES FALLING IN LOVE WITH A FORMER PSYCHIATRIC PATIENT.		
	AGREE	UNDECIDED	DISAGREE
STRATA I	28.8	18.8	62.6
STRATA II	46.7	33.3	20.0
STRATA III	26.7	40.0	33.3
STRATA IV	84.6	7.7	7.7

(E) & QUESTION: Discharged psychiatric patients should be allowed to marry.

(F) QUESTION: It is foolish to marry someone who has had a severe psychiatric illness, even though they seem fully recovered.

Since the questions regarding the marriage of discharged psychiatric patients are somewhat related, they will be discussed together.

Considering the intimacy of a marriage relationship, there was a significance difference ($X^2=17.04$, $df=9$, $p<.04$) between the various types of housing and the responses to a statement concerned with whether or not ex-patients should be allowed to marry.

TABLE XIII: PERCENTAGE OF RESPONDENTS RESPONDING TO THE STATEMENT THAT DISCHARGED PSYCHIATRIC PATIENTS SHOULD BE ALLOWED TO MARRY RESIDENCE TYPE

	DISCHARGED PSYCHIATRIC PATIENTS SHOULD BE ALLOWED TO MARRY.		
	AGREE	UNDECIDED	DISAGREE
STRATA I	50.0	12.5	37.5
STRATA II	43.8	43.8	12.5
STRATA III	73.3	6.7	20.0
STRATA IV	57.2	28.6	14.3

Although 73.3% of the sample population living near the large board and care homes (Strata III) said that discharged psychiatric patients should be allowed to marry, when asked if it were foolish to marry a former patient, 46.7% said that it was foolish to do so.

In contrast, 57.2% of the sample population living in neighborhoods of the Independent Group Homes felt that discharged patients should be allowed to marry. When community residents living near the Independent Group Homes were asked if it was follish to marry a former patient, only 28.6% felt that it was.

(G) QUESTION: A person who has been a patient in a psychiatric hospital is more dangerous than the general population.

An analysis of the responses suggests that respondents living near the large board and care homes (Strata III) perceive former patients to be significantly more dangerous than do respondents in areas of the foster homes with one ex-patient ($T=1.20$, $df=29$, $p<.08$), or than those community residents living near the Independent Group Homes ($T=1.88$, $df=28$, $p<.07$). Those community residents living near the small board and care homes with 2-3 former patients do not differ significantly from the respondents in the other strata.

TABLE XIV: PERCENTAGE OF RESPONDENTS RESPONDING TO THE STATEMENT THAT DISCHARGED PATIENTS ARE MORE DANGEROUS THAN THE GENERAL POPULATION BY RESIDENCE TYPE

	DISCHARGED PSYCHIATRIC PATIENTS ARE MORE DANGEROUS THAN THE GENERAL PUBLIC		
	AGREE	UNDECIDED	DISAGREE
STRATA I	25.1	0.0	75.0
STRATA II	31.3	18.8	50.1
STRATA III	53.3	13.3	33.3
STRATA IV	20.0	20.0	60.0

SUMMARY OF GENERAL ATTITUDE STATEMENTS

A consideration of general attitude statements seemed to indicate that the community residents in our sample population living near the Independent Group Homes expressed more accepting attitudes toward the mentally ill, than did respondents living near all other types of housing. Five of the seven items demonstrated significant differences in favour of the Independent Group Homes. Respondents living near the Independent Group Homes were more willing to have a residence for discharged psychiatric patients in their area, and felt that, at present, former patients are not easy to recognize. Community residents living near the Independent Group Homes did not feel that former patients were more dangerous than were people in general. Former patients were also viewed as being willing to work by the respondents in areas of the

Independent Group Homes. Respondents living in neighborhoods of the Independent Group Homes also expressed greater willingness to tolerate more intimate relationships with the ex-patient, in that they were able to imagine themselves falling in love with a former patient.

Placing former patients into sheltered housing in the community, that makes the patient less socially visible, may be more conducive to social integration. Also, if the discharged patient is housed in facilities that approximates that of the rest of the community in which he is living, he may tend to be regarded as "normal", and become less isolated, than if he were placed in housing more clearly identified as homes for former mental hospital patients.

STAR VIGNETTES: IMPACT OF HOUSING ON ATTITUDES

Since the present study focused on the effect of patient housing on the attitudes of the community, the Star Vignettes of behaviours characteristic of mental illness, will be considered from that perspective. Rejection scores were computed on each of seven different case abstracts, across the different types of housing, to determine if the respondents' attitudes differed depending on residential proximity to different types of after-care facilities.

Table IX illustrates the mean rejection scores of case abstracts of mental illness by resident type, where 1 represents total acceptance and 4 total rejection.

TABLE XV: MEAN REJECTION OF CASE DESCRIPTIONS OF MENTAL ILLNESS BY RESIDENCE TYPE

	RESIDENCE TYPE			
	1 PERSON	2-3 PERSONS	OVER 4 PERSONS	INDEPENDENT GROUP HOMES
PARANOID SCHIZOPHRENIC	3.48	3.71	3.74	3.45
BEHAVIOUR DISORDER	3.03	3.10	3.48	3.02
ALCOHOLIC	3.17	3.06	3.55	2.78
DEPRESSED NEUROTIC	2.45	2.47	2.58	2.70
SIMPLE SCHIZOPHRENIC	2.23	2.30	2.52	2.51
PHOBIC COMPULSIVE	2.03	1.88	1.68	1.81
NORMAL	1.45	1.58	1.28	1.55

A comparison of the mean scores suggested significant differences in terms of housing. Respondents living near the larger board and care homes were significantly more rejecting of the:

1. Paranoid schizophrenic, than respondents living near foster homes for one person ($T=3.35$, $df=29$, $p<.03$). or than the respondents living near the Independent Group Homes ($T=3.07$, $df=27$, $p<.04$).
2. Behaviour disorder, than respondents living near the foster homes ($T=3.21$, $df=29$, $p<.03$), the small board and care homes ($T=1.40$, $df=29$, $p<.06$), or near the Independent Group Homes ($T=2.31$, $df=27$, $p<.02$).

3. Alcoholic, than respondents living near the foster homes ($T=2.63$, $df=29$, $p<.04$), the small board and care homes ($T=3.20$, $df=29$, $p<.01$), or the the Independent Group Homes ($T=3.93$, $df=27$, $p<.001$).

Respondents living near the larger board and care homes were significantly more accepting of the:

1. Phobic compulsive, than respondents living near the foster homes ($T=2.09$, $df=29$, $p<.03$), the small board and care homes ($T=2.99$, $df=29$, $p<.04$) and the Independent Group Homes ($T=3.09$, $df=27$, $p<.05$).

In the case descriptions of the paranoid schizophrenic, the behaviour disorder, and the alcoholic, the person was described as being unpredictable, disruptive, and potentially violent. The respondents living near the larger board and care homes were more rejecting of persons described in such a manner. In contrast, the phobic compulsive was seen as being "careful" and therefore not a threat to anyone. As such, he was more acceptable to community residents.

There were no significant differences in rejection, as indicated by the mean scores, between the respondents living near the foster homes and the Independent Group Homes on any of the six case abstracts presented.

Only in one of the case abstracts, that of the phobic compulsive, were community residents in neighborhoods of the smaller board and care homes (Strata II), significantly more rejecting of the person described, than respondents living in

neighborhoods of the foster homes ($T=1.03$, $df=30$, $p<.03$) or the Independent Group Homes ($T=1.95$, $df=30$, $p<.06$).

Therefore, it was found that community residents living in close proximity to the large board and care homes, were consistently more rejecting and less tolerant of descriptions of persons behaving in ways that were described as paranoid, schizophrenic, a behaviour disorder, and an alcoholic.

When considering the profiles of the persons described as being characteristic behaviours of the mentally ill, the community residents living near the large board and care homes (Strata III) were consistently more rejecting and less tolerant than respondents living near other types of sheltered housing.

On the other hand, there were no clear differences between respondents living near any of the other types of care facilities.

The differences in attitudinal responses between the residents living in neighborhoods of various kinds of sheltered housing, would suggest that the larger board and care homes for the mentally ill may be more restrictive in terms of the former patient's re-adjustment to community living. There may be a disadvantage to the discharged patient if he is placed in those kinds of sheltered housing within the community which evoke the most negative responses from the neighborhood residents.

If certain kinds of behaviours (as described by the Star abstracts), are better tolerated when the ex-patient is in smaller or more independent housing, that is, in housing which is not as easily identified as being for the "mentally ill",

then placing the ex-patient in such facilities may enhance his acceptance by the public and his ultimate reintegration to community living.

Community tolerance of someone acting in an unusual or an unpredictable way, may vary in the way members of the community relate to and/or accept different types of sheltered housing for the mentally ill. It may be that the person is socially defined as mentally ill, by virtue of his housing when we place him in care facilities clearly designated as being for the mentally ill, thereby creating a predisposition in the comunity as to how they will relate to him.

CHAPTER V

STUDY CONCLUSIONS AND IMPLICATIONS

It has been found that community resistance toward the presence of discharged psychiatric patients living within the neighborhood can be related to certain kinds of after-care housing for the mentally ill.

Public attitudes toward the mentally ill may be more negative if the psychiatric patient is placed into housing which is clearly identified as after-care housing for the mentally ill. When discharged psychiatric patients are housed in facilities which closely resemble that of the majority of community residents, the patient becomes less visible as "deviant", and more acceptable as a neighborhood resident.

It was found that clear differences exist between the general public and their attitudes toward different kinds of sheltered housing for the psychiatric patient. The community residents were least accepting of a large board and care home within the neighborhood, and were clearly more favourable towards all other kinds of sheltered housing for the psychiatric patient. Community residents in our sample population were most accepting of foster home care for the mentally ill, and of discharged psychiatric patients living in "Independent Group Home" situations within the community.

The large board and care homes, with more than four residents, seemed to evoke the most negative responses from the public. Not only were community residents least tolerant of that kind of housing for the mentally ill, but respondents living in areas of existing large board and care homes also expressed more rejecting attitudes toward the ex-patient, than did those near other kinds of sheltered housing.

Respondents in our sample population living in neighborhoods of the Independent Group Homes consistently expressed more tolerant attitudes and a greater willingness to associate with persons known to have been in a mental hospital.

On social distance items, the neighbors of the Independent Group Homes in our study population tended to be more accepting, and expressed a greater willingness to associate with the former patient in more intimate relationships, than did the respondents living near all other kinds of sheltered housing.

It was found that general community attitudes in relation to certain beliefs about the mentally ill may be a function of housing. Community residents living in proximity to the Independent Group Homes expressed more liberal attitudes toward and more favourable opinions about the mentally ill.

An analysis of the Star abstracts suggested that the respondents living near the large board and care homes were significantly less tolerant of the paranoid schizophrenic, the

behaviour disorder, and the alcoholic than the respondents living near all other types of sheltered housing.

Phillips (1963) suggested that labelling behaviours as "mental illness" was associated with rejection. Farina (1971) suggested that the perception of an individual was affected if he was believed to be mentally ill. In the present study we found that discharged psychiatric patients living in board and care homes are more easily identified by community residents, than are ex-patients living in an Independent Group Home. Board and care homes, which respondents could identify as being homes for the mentally ill, also evoked more negative responses from neighborhood residents.

If the goal of placing ex-patients within the community is rehabilitation and reintegration to community living, it would be most advisable to place the former patient in a facility which evokes the least negative response from community residents. When the discharged patient is placed in normal housing, that is, in housing which is congruent with the rest of the neighborhood, the community residents may not be as inclined to keep a distance between themselves and the former patient, since the patient would be seen as any other neighborhood resident.

If the large board and care homes evoke negative attitudes in the community, and conveys the message to the public that the people housed there are "deviant" and not capable of looking after themselves, then the discharged psychiatric patient may

continue to remain segregated. The ex-patients living there may continue to have minimal contact with community residents, and the facility will be little more than "a small ward moved to a community setting".

While patient housing may not account for all of the community attitudes, it seems to have an effect on those attitudes. It would appear that negative community attitudes toward certain kinds of sheltered housing has important implications in the former patient's re-adjustment to, and involvement in, community life.

BIBLIOGRAPHY

ASKENSAY, Alexander. Attitudes Toward Mental Health. The Hague, Netherlands, Mouton & Co., 1974.

AVIRAM, Uri and SEGAL, S.P. "Exclusion of the Mentally Ill". Archives of General Psychiatry, July 1973, 29: 126-131.

BENTZ, W.K., EDGERTON, J.W., KHERLOPIAN, A. "Perceptions of Mental Illness Among People in a Rural Area". Mental Hygiene, July 1969, Vol. 53, No. 3, pp. 459-465.

BENTZ, W.K. and EDGERTON, J.W. "Concensus on Attitudes Towards Mental Illness". Archives of General Psychiatry, May 1970, 22: 468-473.

BORD, R.J. "Rejection of the Mentally Ill: Continuities and Further Developments". Social Problems, 1971, 18: 469-509.

COHEN, J. and STRUENING, E. "Opinions about Mental Illness in the Personal of Two Large Mental Hospitals". Journal of Abnormal and Social Psychology, 1962, Vol. 64, No. 5, pp. 349-360.

CROCETTI, G.M. and LEMKAU, P.V. "Public Opinion of Psychiatric Home Care in an Urban Area". American Journal of Public Health, 1963, 53: 409-414.

CROCETTI, Guido. Contemporary Attitudes Toward Mental Illness. University of Pittsburg Press, 1974.

CUMMING, J. and CUMMING, E. Closed Ranks: An Experiment in Mental Health Education. Cambridge, Mass., Harvard University Press, 1957.

CUMMING, J. and CUMMING, E. "On the Stigma of Mental Illness". Community Mental Health Journal, 1965, Vol. 1, No. 2, 135-143.

DOHRENWEND, B.P. and CHIN-SHONG, E. "Social Status and Attitudes Toward Psychological Disorders: The Problem of Tolerance of Deviance". American Sociological Review, 1967, 32: 417-433.

EDGERTON, J.W. and BENTZ, W.K. "Attitudes and Opinions of Rural People About Mental Illness and Program Services". American Journal of Public Health, 1969, 59: 470-477.

FARINA, A. and RING, K. "The Influence of Perceived Mental Illness on Interpersonal Relations". Journal of Abnormal Psychology, 1965, 70: 47-51.

FARINA, A. "Mental Illness and the Impact of Believing Others Know About It". Journal of Abnormal Psychology, 1971, 77: 1-5.

FINAL REPORT OF THE JOINT COMMISSION on Mental Illness and Health, Action for Mental Health, New York, Basic Books, Inc., 1961.

HALPERT, H.P. "Surveys of Public Opinions and Attitudes About Mental Illness". Public Health Reports, 1965, Vol. 80, No. 7, 589-597.

———— "Public Acceptance of the Mentally Ill". Public Health Reports, 1969, 84: 59-84.

HALPERT, H.P. "Public Opinions and Attitudes About Mental Illness", in Social Psychology and Mental Health, H. Wechsler (Ed.), New York, Holt, Rinehart, & Winston, Inc., 1970, pp. 489-504.

GOFFMAN, E. Asylums. Englewood Cliffs, New Jersey, Prentice-Hall, 1963.

LAMB, H.P. and GOERTZEL, V. "Discharged Mental Patients--Are They Really in the Community?" Archives of General Psychiatry, 1971, 24: 29-33.

LAFAVE, H.G., ROOTMAN, I., SYDIAHA, D. and DUCKWORTH, R. "The Ethnic Community and the Definition of the Mental Illness: A Comparative Study of French and Non-French Canadian Towns". Psychiatric Quarterly, 1967, 41: 211-227.

LA PIERE, R.T. "Attitudes vs. Action". Social Forces, 1934, 13:230-237.

LEIGHTON, Alexander H. People of Cover and Woodlot: Communities from the Viewpoint of Social Psychiatry, Vol. II of the Sterling County Study of Psychiatric Disorder and Socio-Cultural Environment. New York, Basic Books, Inc., 1960.

LEMKAU, P.V. and CROCETTI, G.M. "An Urban Population's Opinion and Knowledge about Mental Illness". American Journal of Psychiatry, 1962, 118: 692-700.

MANITOBA MENTAL HEALTH SURVEY. Mental Health/Manitoba, Canadian Mental Health Association, February 1973.

MEYER, J.K. "Attitudes Toward Mental Illness in a Maryland Community". Public Health Reports, 1964, 79: 769-772.

NUNNALLY, Jum C. Popular Conceptions of Mental Health. New York, Holt, Rinehart and Winston, 1961.

OLSHANSKY, S. "Community Aspects of Rehabilitation". in The Rehabilitation of the Mentally Ill. M. Greenblat and M. Simons (Eds.), American Association for the Advancement of Science, 1959, pp. 213-222.

PAGE, Stewart. "The Elusive Character of Psychiatric Stigma". Canada's Mental Health, June, 1974, 22(2): 15-17.

PARSONS, T. "The Mental Hospital as a Type of Organization". in The Patient in the Mental Hospital. M. Greenblatt, D.J. Levinson, and R.H. Williamson (Eds.), Glencoe, Illinois, Free Press, 1957.

PHILLIPS, Derek. "Rejection: A Possible Consequence for Seeking Help for Mental Disorders". American Sociological Review, 1963, 28: 963-972.

———— "Rejection of the Mentally Ill: Influence of Behaviour and Sex". American Sociological Review, 1964, 29: 679-687.

———— "Public Identification and Acceptance of the Mentally Ill". American Journal of Public Health, 1966, 56: 755-763.

———— "Identification of Mental Illness: Its Consequences for Rejection". Community Mental Health Journal, 1967, 3: 762-768.

RABKIN, Judith. "Opinions About Mental Illness: A Review of the Literature". Psychological Bulletin, 1972, 77: 153-171.

———— "Public Attitudes Toward Mental Illness: A Review of the Literature". Schizophrenia Bulletin, 1974, 10: 9-33.

RAPPEPORT, Jonas and LASSEN, George. "Dangerousness--Arrest Rate Comparisons of Discharged Patients and the General Population". American Journal of Psychiatry, 1965, 121: 766-783.

RAMSEY, Glenn and SEIPP, Melita. "Attitudes and Opinions Concerning Mental Illnes". Psychiatric Quarterly, 1948, 2: 428-448.

REDLICH, F.D., HOLLINGSHEAD, A.B., and BELLISS, E. "Social Class Differences in Attitudes Toward Psychiatry". American Journal of Orthopsychiatry, 1955, 25: 60-70.

ROOTMAN, Irving, PHIL, M. and LAFAVE, H. "Are Popular Attitudes Toward the Mentally Ill Changing?" American Journal of Psychiatry, 1969, 126: 147-151.

SPIRO, Herzl, SIASSI, Irad, and CROCETTI, G. "The Issue of Contact with the Mentally Ill". American Journal of Public Health, 1974, 64: 876-879.

STAR, Shirley. "What the Public Thinks About Mental Health and Mental Illness". Unpublished paper presented to the annual meeting of the National Association for Mental Health, Inc., November 19, 1952. Referred to in Crocetti 1974.

TRUTE, Barry. "Social Indicators as Predictors of Social Integration in Saskatchewan and California". Doctoral Dissertation, University of California at Berkeley, 1975.

WHATLEY, C.D. "Social Attitudes Towards Discharged Mental Patients". Social Problems, 1959, 6: 313-320.

WINNIPEG FREE PRESS. August 26, 1975; September 16, 1975. Winnipeg, Manitoba, Canada.

WOODWARD, Julian. "Changing Ideas on Mental Illness and Its Treatment". American Sociological Review, 1951, 16: 443-454.

APPENDIX A

ITEMS TESTED TO FORM THE EXPERIENCE SCALE AND THE SOCIAL DISTANCE SCALE

ITEMS TESTED TO FORM THE SOCIAL DISTANCE SCALE

1. You would not resent the presence of a residence for discharged psychiatric hospital patients in your area. (agree)
2. You would agree to providing board and room for a discharged psychiatric patient in your own home if you had room. (agree)
3. You would trust a woman who had been a patient in a psychiatric hospital as a babysitter for your children. (agree)
4. You would welcome someone who had spent time in a psychiatric hospital to take part in your community functions. (agree)
5. It would be unwise to encourage the close friendship of someone who had been in a psychiatric hospital. (disagree)
6. If you were a manager and were responsible for hiring people to work for you, you would be willing to hire a discharged psychiatric hospital patient. (agree)
7. You would not object to a member of your family dating someone who had been a patient in a psychiatric hospital. (agree)
8. You would strongly discourage your children from marrying someone who had been a patient in a psychiatric hospital. (disagree)
9. You can imagine yourself falling in love with some who had been a patient in a psychiatric hospital. (agree)
10. You would be willing to work on the same job with someone who had been a patient in a psychiatric hospital. (agree)

11. If you were responsible for renting apartments in your building, you would not hesitate to rent living quarters to someone known to have been in a psychiatric hospital. (agree)
12. You would not object to a group of discharged psychiatric patients renting or buying an apartment or house on your street. (agree)
13. If the house next door was for sale, you would object to someone with a history of psychiatric problems buying it. (disagree)

ITEMS TESTED TO FORM THE EXPERIENCE SCALE

1. To your knowledge, have you ever worked with someone who had been a patient in a psychiatric hospital?
2. Has a former psychiatric patient ever visited in your home?
3. Have you ever known anyone who has been a patient in a psychiatric hospital?
4. Have you ever visited a patient in a psychiatric hospital?
5. Have any of your close friends ever been a patient in a psychiatric hospital?
6. Has a member of your family ever been a patient in a psychiatric hospital?

APPENDIX B

THE RESEARCH QUESTIONNAIRE

RESEARCH QUESTIONNAIRE

PART A

1. Age at nearest birthday _____. (Col.5-6)___

2. Sex: 1. male ____
   2. female ____ (Col.7) ____

3. Education (Please check highest completed):
   1. some grade school ____
   2. completed grade school ____
   3. some high school ____
   4. completed high school ____
   5. some vocational school ____
   6. completed vocational school ____
   7. some university ____
   8. completed university degree ____
   9. post graduate studies ____ (Col.8-9)___

4. What is your major occupation? _____
   (If you are retired, please list your former occupation. If you are gainfully employed less than four hours a day please write in the word such as "student" or "housewife" as would apply to your case.) (Col.10-11)___

5. What is the occupation of the major wage earner of your household? _____ (Col.12-13)___

6. Present marital status: (Please check one)
   1. single ____ 4. separated ____
   2. married ____ 5. divorced ____
   3. widowed ____ 6. common law ____ (Col.14) ____

7. What religion were you raised in?
   1. Catholic ____ 4. None ____
   2. Jewish ____ 5. Other ____
   3. Protestant ____ Please specify _____ (Col.15)___

8. What is your present religious preference.
   1. Catholic ____ 4. None ____
   2. Jewish ____ 5. Other ____
   3. Protestant ____ Please specify _____ (Col.16) ____

9. With which ethnic or cultural group do you identify yourself?
   1. Ukranian/Polish ____ 7. Asian ____
   2. British/Scottish/Irish ____ 8. Jewish ____
   3. Scandinavian ____ 9. Metis/Indian ____
   4. French ____ 10. None ____
   5. German ____ 11. Other ____
   6. Other European ____ Please specify _____ (Col.17-18)___

10. Please check the group in which your total household income fell in 1974. (Income of husband, wife, children, and any other source).

1. under $5,000	____	5. $20,001 - 25,000	____
2. $5,001 - 10,000	____	6. $25,001 - 30,000	____
3. $10,001 - 15,000	____	7. $30,001 - 35,000	____
4. $15,001 - 20,000	____	8. over $35,000	____

(Col.19) ____

11. How many people live in your household? _____ (Col.20-21)___

12. What is the age range of people living in this household?
_____ (Col.22-27)___

13. Do you have any children living here?
1. yes ____ 2. no ____ (Col. 28) ___

If yes, what are their ages? _____ (Col.29-32)___

14. How long have you lived in this neighborhood?
_____ (Col.33-35)___

15. How long have you lived in the house you are in now?
_____ (Col.36-38)___

16. In how many different places have you lived in the past five years?
_____ (Col. 39) ___

17. Would you say your neighborhood is mostly:

1.upper class	2.middle class	3.working class	4.lower class

(Col.40)____

18. Would you say the people in this neighborhood are mostly:

1. friendly	2. about average	3. unfriendly

(Col.41) ____

19. Have you ever had to call the police because of a disturbance?
1. yes ____ 2. No ____ (Col.42) ____

If yes, please specify. _____
(Col. 43)____

20. How satisfied are you living in this area?

1. very satisfied	2. satisfied	3.indifferent	4.not satisfied	5. very dissatisfied

(Col.44) ___

20. Are you presently working at a job outside of this house? (Col. 45) ___
1. yes ____ 2. no ____
(If no, skip to # 28)

22. What kind of work do you do? _____ (Col.46-47)___

23. How often do you go out to work? _____ (Col. 48) ___

24. Where is your job located? _____ (Col. 49) ___

25. How long have you been at your present job? _____ (Col.50-52)___

26. How satisfied are you with your present job?

1. very satisfied	2. satisfied	3.indifferent	4. not satisfied	5. very dissatisfied

(Col. 53) ___

27. If you are not employed, when is the last time you had a fulltime job outside of this house? _____ (Col.54-56)___

28. Are you presently taking any courses or doing any studies? (Col. 60)___
1. yes ____ 2. no ____

(If no, skip to #32)

29. What kind of studies are you taking? (e.g.adult education, night courses). _____ (Col. 61) ___

30. How often do you go? _____ (Col. 62) ___

31. How satisfied are you with your studies?

1. very satisfied	2.satisfied	3.indifferent	4.not satisfied	5. very dissatisfied

(Col. 63) ___

32. How ease is it for you to get to a corner store?

1. easy	2. not much trouble	3. difficult

(Col. 65) ___

33. How often do you go there? _____ (Col. 66) ___

34. How easy is it for you to go downtown?

1. easy	2. not much trouble	3. difficult

(Col. 67) ___

35. How often do you go downtown? _____ (Col. 68) ___

36. How easy is it for you to get to a shopping centre?

1. easy 2. not much trouble 3. difficult (Col.69) ____

37. How often do you go there? _____ (Col.70) ____

38. How easy is it for you to get to a grocery store?

1. easy 2. not much trouble 3.difficult (Col.71) ____

39. How often do you go shopping for groceries? _____ (Col.72) ___

40. How easy is it for you to go to a hairdresser or barber?

1. easy 2.not much trouble 3.difficult (Col. 73) ___

41. How often do you go there? _____ (Col. 74) ____

42. Do you ever use the bus?
1. yes ____ 2. no ____ (Col. 5) ____

43. How often do you use the bus? _____ (Col. 6) ____

44. What is your most frequently used method of transportation? _____ (Col.7) ____

45. Do you read the newspaper?
1. yes ____ 2. no ____ (Col. 8) ____

46. How often do you read the newspaper? _____ (Col. 9) ____

47. How often do you use the telephone? _____ (Col.10) ____

48. If you had to contact a lawyer, would it be:
1. easy ____
2. not much trouble ____
3. difficult ____ (Col.11) ____

49. If you had to contact the fire department, would it be:
1. easy ____
2. not much trouble ____
3. difficult ____ (Col.12) ____

50. If you had to call an ambulance, would it be:
1. easy ____
2. not much trouble ____
3. difficult ____ (Col.13) ____

51. If you had to call a doctor, would it be:
    1. easy ____
    2. not much trouble ____
    3. difficult ____ (Col. 14) ____

52. If you had to contact the police, would it be:
    1. easy ____
    2. not much trouble ____
    3. difficult ____ (Col.15) ____

53. Did you vote in the last election?
    1. yes ____ 2. no ____ 3. don't remember ____ (Col.16) ____

54. Do you usually vote in elections?
    1. yes ____ 2. no ____ (Col.17) ____

55. Do you ever go out to the movies?
    1. yes ____ 2. no ____ (Col.20) ____

56. With whom do you usually go? _____ (Col. 21) ____

57. How often do you go out to the movies? _____ (Col.22) ____

58. Do you ever go out to a pub or bar?
    1. yes ____ 2. no ____ (Col.23) ____

59. How often do you go out to a pub or bar? _____ (Col.24) ____

60. With whom do you usually go? _____ (Col.25) ____

61. Do you ever go out to watch a sporting event (e.g. hockey, football)?
    1. yes ____ 2. no ____ (Col.26) ____

62. How often do you go out to watch a sporting event?
    _____ (Col.27) ____

63. With whom do you usually go? _____ (Col.28) ____

64. Do you ever go to church?
    1. yes ____ 2. no ____ (Col.29) ____

65. How often do you go to church? _____ (Col.30) ____

66. With whom do you usually go? _____ (Col.31) ____

67. Do you participate in any formal organizations?
    1. yes ____ 2. no ____ (Col.32) ____

    If yes, please list them _____
    _____ (Col.33-34) ____

68. Do you ever go out to a community club or social organization?
1. yes ____ 2. no ____ (Col.35) ____

69. With whom do you usually go? _____ (Col.36) ____

70. How often do you go out to a community club or social organization?
_____ (Col.37) ____

71. Do you ever go window shopping?
1. yes ____ 2. no ____ (Col.38) ____

72. How often do you go window shopping? _____ (Col.39) ____

73. With whom do you usually go window shopping?
_____ (Col.40) ____

74. Do you ever go to a park?
1. yes ____ 2. no _____ (Col.41) ____

75. How often do you usually go to a park? _____ (Col. 42) ____

76. With whom do you usually go? _____ (Col.43) ____

77. Do you ever go out to take part in a sporting event (E.G. bowling, golf)?
1. yes ____ 2. no ____ (Col.44) ____

78. How often do you go out to take part in a sporting event?
_____ (Col.45) ____

79. With whom do you usually go? _____ (Col.46) ____

80. Do you ever go to a party?
1. yes ____ 2. no ____ (Col.47) ____

81. How often do you go to a party? _____ (Col.48) ____

82. With whom do you usually go? _____ (Col.49) ____

83. How satisfied are you with the number of activities you participate in?

1. very satisfied	2.satisfied	3.indifferent	4. not satisfied	5. very dissatisfied

(Col.50) ____

84. Do you have three close friends?
1. yes _____ 2. no _____ (Col.55) ____

85. In what part of the city do they live? _____ (Col.56) ____

86. How often do you get together with these friends? _____ (Col.57) ____

87. In describing you and your friends (in general), would you say you are:
1. very close ____
2. close ____
3. not close ____
4. just know each other ____ (Col.58) ____

88. How satisfied are you with the amount of time you spend with your friends?

1. very satisfied	2.satisfied	3.indifferent	4. not satisfied	5. very dissatisfied

(Col.59) ____

89. How satisfied are you with the number of friends that you have?

1. very satisfied	2.satisfied	3.indifferent	4. not satisfied	5. very dissatisfied

(Col.60) ____

90. How many of your neighbors do you know other than just to say hello to? _____ (Col.61) ____

91. How often do you get together with them? _____ (Col.62) ____

92. In describing you and your neighbors, would you say you are:
1. very close ____
2. close ____
3. not close ____
4. just know each other ____
5. don't know each other ____ (Col.63) ____

93. How satisfied are you with the amount of contact you have with your neighbors?

1. very satisfied	2.satisfied	3.indifferent	4. not satisfied	5. very dissatisfied

(Col.64) ____

94. Do you ever get together with members of your immediate family? (e.g. children, parents, brothers and sisters)
1. yes ____ 2. no ____ (Col.65) ____

95. How often do you get together with members of your immediate family? _____ (Col.66) ____

96. In terms of your immediate family, would you say you are:
1. very close ____
2. close ____
3. not close ____
4. just know each other ____ (Col.67)____

97 How satisfied are you with the amount of time you spend with your family?

1. very satisfied	2.satisfied	3.indifferent	4. not satisfied	5. very dissatisfied

(Col.68) ____

98. Do you have any relatives, other than your immediate family, in this city?
1. yes ____ 2. no ____ (Col.69) ____

99. Do you ever see other relatives besides your immediate family?
1. yes ____ 2. no ____ (Col.70) ____

100. How often do you get together with your other relatives?
_____ (Col.71) ____

101. In describing your relationship with your other relatives, would you say you are:
1. very close ____
2. close ____
3. not close ____
4. just know each other ____
5. don't know each other ____ (Col.72)____

102. How satisfied are you with the amount of time you spend with your other relatives?

1. very satisfied	2.satisfied	3.indifferent	4. not satisfied	5. very dissatisfied

(Col.73) ____

103. Would you say that most of your contact is with people of:

1. the same sex	2. the opposite sex	3. both sexes

(Col.74) ____

104. If you are not living alone, would you say your relationship with the people living in this house is:
1. very close ____
2. close ____
3. not close ____
4. just know each other ____ (Col.75) ____

105. How satisfied are you with your relationship with the people living in this house?

1. very satisfied	2.satisfied	3.indifferent	4. not satisfied	5. very dissatisfied

(Col.76) ____

106. Who are the people with whom you are the friendliest?

1. people who live in this house ____
2. immediate family ____
3. other relatives ____
4. other friends in community ____
5. neighbors ____

(Col.77) ____

RESEARCH QUESTIONNAIRE

PART B

1. What do you feel is the most pressing social problem in the area in which you live?

1. care for the aged ____
2. family breakdown ____
3. taxes ____
4. crime ____
5. drugs and alcohol ____
6. education ____
7. lack of social services ____
8. mental health ____
9. housing ____
10. services for Indians ____
11. venereal disease ____
12. traffic, transportation ____
13. other ____
14. don't know ____ (Col.5-6)____

2. Please rank in order what you see as the next three most important issues.

1. _____ (Col.7-8)____
2. _____ (Col.9-10)___
3. _____ (Col.11-12)___

3. Do you know of any discharged psychiatric patient living in your area?

1. yes ____ 2. no ____ (Col.13)____

4. The problems in your area would change if discharged psychiatric patients lived in your community.

1.increase 2.stay the same 3. decrease 4.don't know

(Col.14)____

5. A person who has been a patient in a psychiatric hospital is more dangerous than the general population.

1.strongly agree 2.agree 3.undecided 4.disagree 5.strongly disagree (Col.15)____

6. The value of your property would be reduced if a home for discharged psychiatric patients were located in your area.

1.strongly agree 2.agree 3.undecided 4.disagree 5.strongly disagree

(Col.16) ____

7. You would not resent the presence of a residence for discharged psychiatric hospital patients in your area.

1.strongly agree 2.agree 3.undecided 4.disagree 5.strongly disagree

(Col.17)____

8. You would not object to a group of discharged psychiatric patients renting or buying an apartment or house on your street.

1.strongly agree	2.agree	3.undecided	4.disagree	5.strongly disagree	(Col.18)___

9. You would agree to providing board and room for a discharged psychiatric patient in your own home if you had room.

1.strongly agree	2.agree	3.undecided	4.disagree	5.strongly disagree	(Col.19)___

10. A person with a mental illness has a better chance of getting better if he stays living in the community, instead of going to a psychiatric hospital.

1.strongly agree	2.agree	3.undecided	4.disagree	5.strongly disagree	(Col.20)__

11. It is often better for a person with a mental illness to live with his or her family instead of being in a mental hospital.

1.strongly agree	2.agree	3.undecided	4.disagree	5.strongly disagree	(Col.21)__

12. People who have been in a psychiatric hospital are no more likely to commit crimes than people who have never been in a psychiatric hospital.

1.strongly agree	2.agree	3.undecided	4.disagree	5.strongly disagree	(Col.22)___

13. People with some kinds of psychiatric disorders can be taken care of in the community.

1.strongly agree	2.agree	3.undecided	4.disagree	5.strongly disagree	(Col.23)___

14. People who have had a psychiatric illness should have a say about where and how they live.

1.strongly agree	2.agree	3.undecided	4.disagree	5.strongly disagree	(Col.24)___

15. Even though people who have been discharged from a psychiatric hospital may seem all right, they should not be allowed to marry.

1.strongly agree	2.agree	3.undecided	4.disagree	5.strongly disagree	(Col.25)___

16. Mental illness is an illness like any other disease.

1.strongly agree	2.agree	3.undecided	4.disagree	5.strongly disagree	(Col.26)___

17. Persons who are or have been in a psychiatric hospital are easy to tell from normal people.

1.strongly agree | 2.agree | 3.undecided | 4.disagree | 5.strongly disagree (Col.27)___

18. There is little that can be done for psychiatric patients except to see that they are comfortable and well fed.

1.strongly agree | 2.agree | 3.undecided | 4.disagree | 5.strongly disagree (Col.28)___

19. Most discharged psychiatric hospital patients are willing to work.

1.strongly agree | 2.agree | 3.undecided | 4.disagree | 5.strongly disagree (Col.29)___

20. You would trust a woman who had been a patient in a psychiatric hospital as a babysitter for your children.

1.strongly agree | 2.agree | 3.undecided | 4.disagree | 5.strongly disagree (Col.30)___

21. Many ex-patients are capable of skilled labor, even though in some ways they still have severe problems.

1.strongly agree | 2.agree | 3.undecided | 4.disagree | 5.strongly disagree (Col.31)___

22. Many people who have never been patients in a mental hospital are more mentally ill than many hospitalized psychiatric patients.

1.strongly agree | 2.agree | 3.undecided | 4.disagree | 5.strongly disagree (Col.32)___

23. Most people who have been in a psychiatric hospital never get well enough to be able to live on their own again.

1.strongly agree | 2.agree | 3.undecided | 4.disagree | 5.strongly disagree (Col.33)___

24. It would be impossible to have a close friendship with someone who had been a patient in a psychiatric hospital.

1.strongly agree | 2.agree | 3.undecided | 4.disagree | 5.strongly disagree (Col.34)___

25. Most persons who have been in a psychiatric hospital don't care how they look anymore.

1.strongly agree 2.agree 3.undecided 4.disagree 5.strongly disagree (Col.35)__

26. It is foolish for a woman/man to marry a man/woman who has had a severe psychiatric illness, even though he seems fully recovered.

1.strongly agree 2.agree 3.undecided 4.disagree 5.strongly disagree (Col.36)__

27. Most patients in a psychiatric hospital are capable of forming good relationships with other people.

1.strongly agree 2.agree 3.undecided 4.disagree 5.strongly disagree (Col.37)__

28. People who are or have been in a psychiatric hospital should be prevented from having children.

1.strongly agree 2.agree 3.undecided 4.disagree 5.strongly disagree (Col.38)__

29. People who have had a mental illness should not be allowed to vote.

1.strongly agree 2.agree 3.undecided 4.disagree 5.strongly disagree (Col.39)__

30. Discharged psychiatric patients should be closely guarded.

1.strongly agree 2.agree 3.undecided 4.disagree 5.strongly disagree (Col.40)__

31. Once a person has been a patient in a psychiatric hospital for a certain period of time, he/she should remain locked up.

1.strongly agree 2.agree 3.undecided 4.disagree 5.strongly disagree (Col.41)__

32. If a home for discharged psychiatric patients were located in your community, the former patients would be allowed to take part in community affairs.

1.strongly agree 2.agree 3.undecided 4.disagree 5.strongly disagree (Col.42)__

33. You would selcome someone who had spent time in a psychiatric hospital to take part in your community functions.

1.strongly agree | 2.agree | 3.undecided | 4.disagree | 5.strongly disagree (Col.43)___

34. If the house next door was for sale, you would object to someone with ahistory of psychiatric problems buying it.

1.strongly agree | 2.agree | 3.undecided | 4.disagree | 5.strongly disagree (Col.44)___

35. It would be unwise to encourage the close friendship of someone who had been in a psychiatric hospital.

1.strongly agree | 2.agree | 3.undecided | 4.disagree | 5.strongly disagree (Col.45)___

36. If you were a manager and were responsible for hiring people to work for you, you would be willing to hire a discharged psychiatric hospital patient.

1.strongly agree | 2.agree | 3.undecided | 4.disagree | 5.strongly disagree (Col.46)___

37. You would not object to a member of your family dating someone who had been a patient in a psychiatric hospital.

1.strongly agree | 2.agree | 3.undecided | 4.disagree | 5.strongly disagree (Col.47)___

38. You would strongly discourage your children from marrying someone who had been a patient in a psychiatric hospital.

1.strongly agree | 2.agree | 3.undecided | 4.disagree | 5.strongly disagree (Col.48)__

39. You can imagine yourself falling in love with someone who had been a patient in a psychiatric hospital.

1.strongly agree | 2.agree | 3.undecided | 4.disagree | 5.strongly disagree (Col.49)___

40. You would be willing to work on the same job with someone who had been a patient in a psychiatric hospital.

1.strongly agree | 2.agree | 3.undecided | 4.disagree | 5.strongly disagree (Col.50)___

41. If you were responsible for renting apartments in your building, you would not hesitate to rent living quarters to someone known to have been in a psychiatric hospital.

1.strongly agree 2.agree 3.undecided 4.disagree 5.strongly disagree (Col.51)__

42. The age of a person with a mental illness makes a difference in the way you relate to them.

1.strongly agree 2.agree 3.undecided 4.disagree 5.strongly disagree (Col.52)___

43. If a family in your community took a former psychiatric patient into their home as a boarder, the patient would be excluded from taking part in the community.

1.strongly agree 2.agree 3.undecided 4.disagree 5.strongly disagree (Col.53)___

44. The people in your community would be opposed if someone on your street took in 2-3 discharged psychiatric patients as boarders.

1.strongly agree 2.agree 3.undecided 4.disagree 5.strongly disagree (Col.54)___

45. To your knowledge, have you ever worked with someone who had been a patient in a psychiatric hospital?

1. yes ____ 2. no _____ (Col.55)___

46. Has a former psychiatric patient ever visited in your home?

1. yes ____ 2.no _____ (Col.56)___

47. It makes a difference in how you feel toward the discharged psychiatric patient, depending on whether the person is male or female.

1.strongly prefer male 2.prefer male 3. strongly prefer female 4.prefer female 5.makes no difference (Col.57)___

48. Now close is the nearest psychiatric hospital from where you live?

_____ (Col.58)___

49. Have you ever known anyone who has been a patient in a psychiatric hospital?

1.yes _____ 2. no _____ (Col.59)___

50. Have you ever visited a patient in a psychiatric hospital?
1. yes ____ 2. no ____ (Col.60)____

51. Have any of your close friends ever been a patient in a psychiatric hospital?
1. yes ____ 2. no ____ (Col.61)____

52. Has a member of your family ever been a patient in a psychiatric hospital?
1. yes ____ 2. no ____ (Col.62)____

53. To your knowledge, has a discharged psychiatric hospital patient ever caused any damage to your property?
1. yes ____ 2. no ____ (Col.63)____

If yes, please specify. _____
_____

54. If three to four discharged psychiatric patients rented an apartment or house in your neighborhood, they would be accepted to take part in the community.

1.strongly agree ____ 2.agree ____ 3.undecided ____ 4.disagree ____ 5.strongly disagree (Col.64)___

55. Your community would agree to a halfway house for former psychiatric patients being opened in your neighborhood.

1.strongly agree ____ 2.agree ____ 3.undecided ____ 4.disagree ____ 5.strongly disagree (Col.65)___

56. You would not want any mentally ill people living in this community.

1.strongly agree ____ 2.agree ____ 3.undecided ____ 4.disagree ____ 5.strongly disagree (Col.66)___

1. I'm thinking of a man - let's call him Frank Jones - who is very suspicious; he doesn't trust anybody, and he's sure that everybody is against him. Sometimes he thinks that people he sees on the street are talking about him or following him around. A couple of times, now, he has beaten up men who didn't even know him. The other night, he began to curse his wife terribly, then he hit her and threatened to kill her because, he said, she was working against him too, just like everyone else.

(a) How would you feel about having someone like this for a neighbour? Would you say that you would be definitely willing, probably willing, probably unwilling, or definitely unwilling to have someone like this for a neighbour?

(Col. __) ___

___ DW ___ PW ___ PU ___ DU

(b) How would you feel about having this person join your favorite club? Would you say that you would be definitely willing, probably willing, probably unwilling or definitely unwilling to have him join your favorite club?

(Col. __) ___

___ DW ___ PW ___ PU ___ DU

(c) How would you feel about working on the same job with someone like this? Would you be definitely willing, probably willing, probably unwilling or definitely unwilling to work on the same job with him?

(Col.___)___

___ DW ___ PW ___ PU ___ DU

(d) If you lived in an apartment block, would you be willing to share the apartment with someone like this? Would you say that you would be definitely willing, probably willing, probably unwilling or definitely unwilling to share the apartment with someone like this?

(Col.__)___

___ DW ___ PW ___ PU ___ DU

(e) How would you feel about having one of your children marry someone like this? Would you be definitely willing, probably willing, probably unwilling or definitely unwilling to have one of your children marry someone like this person?

(Col.__) ___

___ DW ___ PW ___ PU ___ DU

2. Now here's a young woman in her twenties, let's call her Betty Smith. . . she has never had a job, and she doesn't seem to want to go out and look for one. She is a very quiet girl, she doesn't talk much to anyone - even her own family, and she acts like she is afraid of people, especially young men her own age. She won't go out with anyone, and whenever someone comes to visit her family, she stays in her own room until they leave. She just stays by herself and day-dreams all the time, and shows no interest in anything or anybody.

(a) How would you feel about having someone like this for a neighbour? Would you say that you would be definitely willing, probably willing, probably unwilling or definitely unwilling to have someone like this for a neighbour?

(Col.__) ___

___ DW ___ PW ___ PU ___ DU

(b) How would you feel about having this person join your favorite club? Would you say that you would be definitely willing, probably willing, probably unwilling, or definitely unwilling to have him join your favorite club?

(Col.__) ___

___ DW ___ PW ___ PU ___ DU

(c) How would you feel about working on the same job with someone like this? Would you be definitely willing, probably willing, probably unwilling or definitely unwilling to work on the same job with her?

(Col.__) ___

___ DW ___ PW ___ PU ___ DU

(d) If you lived in an apartment block,would you be willing to share the apartment with someone like this? Would you say that you would be definitely willing, probably willing, probably unwilling or definitely unwilling to share the apartment with someone like this?

(Col.__) ___

___ DW ___ PW ___ PU ___ DU

(e) How would you feel about having one of your children marry someone like this? Would you be definitely willing, probably willing, probably unwilling or definitely unwilling to have one of your children marry someone like this person?

(Col.__) ___

___ DW ___ PW ___ PU ___ DU

3. Here's another kind of man; we can call him George Brown. He has a good job and is doing pretty well at it. Most of the time he gets along all right with people, but he is always very touchy and he always loses his temper quickly, if things aren't going his way, or if people find fault with him. He worries a lot about little things, and he seems to be moody and unhappy all the time. Everything is going along all right for him, but he can't sleep nights, brooding about the past, and worrying about things that "might" go wrong.

(a) How would you feel about having someone like this for a neighbour? Would you say that you would be definitely willing, probably willing, probably unwilling, definitely unwilling to have someone like this for a neighbour?

(Col. __) ___

___ DW ___ PW ___ PU ___ DU

(b) How would you feel about having this person join your favorite club? Would you be definitely willing, probably willing, probably unwilling or definitely unwilling to have him join your favorite club?

(Col.__) ___

___ DW ___ PW ___ PU ___ DU

(c) How would you feel about working on the same job with someone like this? Would you be definitely willing, probably willing, probably unwilling or definitely unwilling to work on the same job with him?

(Col.__) ___

___ DW ___ PW ___ PU ___ DU

(d) If you lived in an apartment block, would you be willing to share the apartment with someone like this? Would you say that you would be definitely willing, probably willing, probably unwilling, or definitely unwilling to share the apartment with someone like this?

(Col.__) ___

___ DW ___ PW ___ PU ___ DU

(e) How would you feel about having one of your children marry someone like this? Would you be definitely willing, probably willing, probably unwilling or definitely unwilling to have one of your children marry someone like this person?

(Col.__) ___

___ DW ___ PW ___ PU ___ DU

4. How about Bill Williams? He never seems to be able to hold a job very long, because he drinks so much. Whenever he has money in his pocket, he goes on a spree; he stays out till all hours drinking, and never seems to care what happens to his wife and children. Sometimes he feels very bad about the way he treats his family; he begs his wife to forgive him and promises to stop drinking, but he always goes off again.

(a) How would you feel about having someone like this for a neighbour? Would you say that you would be definitely willing, probably willing, probably unwilling or definitely unwilling to have someone like this for a neighbour?

(Col.__)___

___ ___ ___ ___
DW PW PU DU

(b) How would you feel about having this person join your favorite club? Would you say that you would be definitely willing, probably willing, probably unwilling or definitely unwilling to have him join your favorite club?

(Col.__)___

___ ___ ___ ___
DW PW PU DU

(c) How would you feel about working on the same job with someone like this? Would you be definitely willing, probably willing, probably unwilling or definitely unwilling to wrok on the same job with him?

(Col.__)___

___ ___ ___ ___
DW PW PU DU

(d) If you lived in an apartment block, would you be willing to share the apartment with someone like this? Would you say that you would be definitely willing, probably willing, probably unwilling or definitely unwilling to share the apartment with someone like this?

(Col.__)___

___ ___ ___ ___
DW PW PU DU

(e) How would you feel about having one of your children marry someone like this? Would you be definitely willing, probably willing, probably unwilling or definitely unwilling to have one of your children marry someone like this person?

(Col.__)___

___ ___ ___ ___
DW PW PU DU

5. Here's a different sort of girl - let's call her Mary White. She seems happy and cheerful; she's pretty, has a good job, and is engaged to marry a nice young man. She has loads of friends; everybody likes her, and she's always busy and active. However, she just can't leave the house without going gack to see whether she left the gas stove lit or not. And she always goes back again just to make sure she locked the door. And one other thing about her, she's afraid to ride up and down in elevators; she just won't go any place where she'd have to ride in an elevator to get there.

(a) How would you feel about having someone like this for a neighbour? Would you say that you would be definitely willing, probably willing, probably unwilling or definitely unwilling to have someone like this for a neighbour?

(Col.__)___

___ ___ ___ ___
DW PW PU DU

(b) How would you feel about having this person join your favorite club? Would you say that you would be definitely willing, probably willing, probably unwilling or definitely unwilling to have him join your favorite club?

(Col.__)___

___ ___ ___ ___
DW PW PU DU

(c) How would you feel about working on the same job with someone like this? Would you be definitely willing, probably willing, probably unwilling or definitely unwilling to work on the same job with her?

(Col.__)___

___ ___ ___ ___
DW PW PU DU

(d) If you lived in an apartment block, would you be willing to share the apartment with someone like this? Would you say that you would be definitely willing, probably willing, probably unwilling to definitely unwilling to share the apartment with someone like this?

(Col.__)___

___ ___ ___ ___
DW PW PU DU

(e) How would you feel about having one of your children marry someone like this? Would you be definitely willing, probably willing, probably unwilling or definitely unwilling to have one of your children marry someone like this person?

(Col.__)___

___ ___ ___ ___
DW PW PU DU

6. Now the next person I'd like to describe is a young man, Bob Grey. He comes from a good family, but he prefers to hang about in the dreary sections of town, and spends much of his time with street gangs. He can never hold a job for long because he's always having arguments with the boss. However, he is very charming and nice to be with. Unfortunately, he never seems to be able to tell the truth. He is always borrowing money from his family's friends that he never bothers to pay back. His parents are very upset about the way he acts, but he pays no attention to them.

(a) How would you feel about having someone like this for a neighbour? Would you say that you would be definitely willing, probably willing, probably unwilling or definitely unwilling to have someone like this for a neighbour?

(Col.__)___

___ DW ___ PW ___ PU ___ DU

(b) How would you feel about having this person join your favorite club? Would you say that you would be definitely willing, probably willing, probably unwilling, or definitely unwilling to have him join your favorite club?

(Col.__)___

___ DW ___ PW ___ PU ___ DU

(c) How would you feel about working on the same job with someone like this? Would you be definitely willing, probably willing, probably unwilling or definitely unwilling to work on the same job with him?

(Col.__)___

___ DW ___ PW ___ PU ___ DU

(d) If you lived in an apartment block, would you be willing to share the apartment with someone like this? Would you say that you would be definitely willing, probably willing, probably unwilling or definitely unwilling to share the apartment with someone like this?

(Col.__)___

___ DW ___ PW ___ PU ___ DU

(e) How would you feel about having one of your children marry someone like this? Would you be definitely willing, probably willing, probably unwilling or definitely unwilling to have one of your children marry someone like this person?

(Col.__)___

___ DW ___ PW ___ PU ___ DU

7. Now here's a description of a man we can call John Miller. Imagine that he is a respectable person living in your neighborhood. He is happy and cheerful, has a good enough job, and is fairly well satisfied with it. He is always busy and has quite a few friends who think he is easy to get along with most of the time. Within the next few months, he plans to marry a nice young woman he is engaged to.

(a) How would you feel about having someone like this for a neighbour? Would you say that you would be definitely willing, probably willing, probably unwilling or definitely unwilling to have someone like this for a neighbour?

(Col.__) ___

___ DW ___ PW ___ PU ___ DU

(b) How would you feel about having this person join your favorite club? Would you say that you would be definitely willing, probably willing, probably unwilling or definitely unwilling to have him join your favorite club?

(Col.__)___

___ DW ___ PW ___ PU ___ DU

(c) How would you feel about working on the same job with someone like this? Would you be definitely willing, probably willing, probably unwilling or definitely unwilling to work on the same job with him?

(Col.__)___

___ DW ___ PW ___ PU ___ DU

(d) If you lived in an apartment block, would you be willing to share the apartment with someone like this? Would you say that you would be definitely willing, probably willing, probably unwilling or definitely unwilling to share the apartment with someone like this?

(Col.__)___

___ DW ___ PW ___ PU ___ DU

(e) How would you feel about having one of your children marry someone like this? Would you be definitely willing, probably willing, probably unwilling, or definitely unwilling to have one of your children marry someone like this person?

(Col.__)___

___ DW ___ PW ___ PU ___ DU

Listed below are a number of statements concerning personal attitudes and traits. Read each item and decided whether the statement is true or false as it pertains to you personally. Circle T (true) or F (false) in the columns preceding the statements.

T F 1. Before voting I thoroughly investigate the qualifications of all candidates.

T F 2. I never hesitate to go out of my way to help someone in trouble.

T F 3. It is sometimes hard for me to go on with my work if I am not encouraged.

T F 4. I have never intensely disliked anyone.

T F 5. On Occasion I have had doubts about my ability to succeed in life.

T F 6. I sometimes feel resentful when I don't get my way.

T F 7. I am always careful about my manner of dress.

T F 8. My table manners at home are as good as when I eat out in a resturant.

T F 9. If I could get into a movie withoug paying and be sure I was not seen, I would probably do it.

T F 10. On a few occasions, I have given up doing something because I thought too little of my ability.

T F 11. I like to gossip at times.

T F 12. There have been times when I felt like rebelling against people in authority even though I knew they were right.

T F 13. No matter who I'm talking to, I'm always a good listener.

T F 14. I can remember "playing sick" to get out of something.

T F 15. There have been occasions when I took advantage of someone.

T F 16. I'm always willing to admit it when i make a mistake.

T F 17. I always try to practice what I preach.

T F 18. I don't find it particularly difficult to get along with loud-mouthed, obnoxious people.

T F 19. I sometimes try to get even, rather than forgive and forget.

T F 20. When I don't know something I don't at all mind admitting it.

T F 21. I am always curteous, even to people who are disagreeable.

T F 22. At times I have really insisted on having things my own way.

T F 23. There have been occasions when I felt like smashing things.

T F 24. I would never think of letting someone else be punished for my wrongdoing.

T F 25. I never resent being asked to return a favour.

T F 26. I have never been irked when people expressed ideas very different from my own.

T F 27. I never make a long trip without checking the safety of my car.

T F 28. There have been times when I was quite jealous of the good fortune of others.

T F 29. I have almost never felt the urge to tell someone off.

T F 30. I am sometimes irritated by people who ask favors of me.

T F 31. I have never felt that I was punished without cause.

T F 32. I sometimes think when people have a misfortune they only get what they deserve.

T F 33. I have never deliberately said something that hurt someone's feelings.