

Nurses' Attitudes towards Mentally Ill Patients

by

Kathy Quee

B.Sc., Texas Women's University, 1976

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SCIENCE IN NURSING

in

THE FACULTY OF GRADUATE STUDIES

The School of Nursing

We accept this thesis as conforming
to the required standard

The University of British Columbia School of Nursing

August 1996

© Kathy Quee, 1996

In presenting this thesis in partial fulfilment of the requirements for an advanced degree at the University of British Columbia, I agree that the Library shall make it freely available for reference and study. I further agree that permission for extensive copying of this thesis for scholarly purposes may be granted by the head of my department or by his or her representatives. It is understood that copying or publication of this thesis for financial gain shall not be allowed without my written permission.

School
Department of Nursing

The University of British Columbia
Vancouver, Canada

Date August 28, 1996

ABSTRACT

Patients who are physically and mentally ill are increasingly cared for by local general hospital medical-surgical nurses. The purpose of this descriptive survey study was to (a) describe the attitudes of medical-surgical nurses towards the mentally ill, (b) identify factors that affect medical-surgical nurses' caring for mentally ill patients, and (c) identify and describe the relationship between medical-surgical nurses' attitudes towards the mentally ill and selected variables.

The sample consisted of 113 randomly selected registered nurses employed full or part-time on medical or surgical units in general hospitals throughout British Columbia. Attitudes were measured using the Opinions About Mental Illness (OMI) developed by Cohen and Struening (1962). Participants also completed a general demographic questionnaire which asked what factors nurses felt affected their ability to care for mentally ill patients.

The majority of the nurses in the sample were prepared at the diploma level and worked in urban areas. The average length of nursing experience was 13 years. Most respondents had psychiatric clinical experience in their education with no further inservices or educational training on care of mentally ill patients. Approximately one-half of the nurses had a personal experience with individuals diagnosed with a mental illness.

Data revealed lower scores than previous studies on the OMI factors of Authoritarianism, Social Restrictiveness, and Interpersonal Etiology, indicating a more positive view of the mentally ill. Higher scores on

Benevolence and lower scores on Mental Hygiene Ideology indicate a paternalistic need to care for these patients and a less optimistic view of mental illness.

Computation of the Pearson r coefficient revealed that the greatest influence in decreasing socially restrictive attitudes towards the mentally ill is advanced education beyond the diploma level. Findings also indicated that nurses who did not have additional education in the care of the mentally ill were more likely to ascribe to a belief in Interpersonal Etiology as a cause of mental illness than were those with further education. Major factors that nurses identified as affecting their ability to care for mentally ill patients were a lack of time to care for mentally ill patients, and a lack of knowledge and experience with mentally ill patients.

TABLE OF CONTENTS

Abstract	ii
Table of Contents	iv
List of Tables	viii
CHAPTER ONE INTRODUCTION	1
Background to the Problem	1
Problem Statement	3
Purpose	4
Conceptual Basis	5
Research Questions	6
Definitions of Terms	7
Assumptions	8
Limitations	8
CHAPTER TWO LITERATURE REVIEW	10
Review of Related Research	10
Attitudes	10
Attitudes of Nurses towards Mentally Ill Patients	12

CHAPTER THREE METHODS	19
Research Design	19
Instruments	19
Opinions About Mental Illness	19
General Questionnaire	22
Procedure	22
Sample	22
Data Collection	23
Data Analysis	23
Human Rights and Ethical Considerations	25
Sample Characteristics	25
Sample Response	25
Sample Demographics	26
Education and Personal Experience with Mentally Ill Patients	26
CHAPTER FOUR PRESENTATION OF RESULTS	29
Research Question 1:	
Nurses Attitudes Towards Mentally Ill Patients	29
Research Question 2:	
Factors Affecting Respondents Care of Mentally Ill Patients	33

Research Question 3:	
Relationship of Variables to Attitudes Towards the Mentally Ill	39
Additional Findings	40
CHAPTER FIVE DISCUSSION OF RESULTS	42
Comparison of the Sample to the Population	42
Attitudes of Nurses Towards the Mentally Ill	42
Relationship of Variables to Attitudes Towards the Mentally Ill and Factors that Influence Care of the Mentally Ill	47
OMI Tool	49
Summary of Findings	50
CHAPTER SIX CONCLUSIONS AND IMPLICATIONS	51
Conclusions	51
Implication for Nursing Practice	52
Implications for Nursing Education	54
Implication for Nursing Research	56
REFERENCES	58
APPENDIX A OPINIONS ABOUT MENTAL ILLNESS	63

APPENDIX B INFORMATION LETTER	66
APPENDIX C ETHICS APPROVAL LETTER	67
APPENDIX D GENERAL QUESTIONNAIRE	68
APPENDIX E PERSONAL COMMUNICATION DR. STRUENING	71

LIST OF TABLES

Table

1	Kuder-Richardson Formula 20 reliability coefficients and Thomson's pooling square validity coefficients	21
2	Demographic Characteristics of Respondents (Categorical Variables)	27
3	Demographic Characteristics of Respondents (Continuous Variables)	28
4	Education and Personal Experience with Mentally Ill Patients	28
5	OMI Questionnaire: Range, Mean and Standard Deviations	30
6	Comparison of OMI Mean Results	32
7	Factors Affecting Care of the Mentally Ill	34
8	Relationship of Variables to Attitudes Towards the Mentally Ill	40
9	Comparison of Sample to Population of British Columbia Nurses	43
10	Comparison to Previous Studies	44

CHAPTER ONE

INTRODUCTION

Background to the Problem

In the mid 1950s, when chlorpromazine, the first antipsychotic drug, became available for the treatment of the mentally ill, it became apparent that patients could be maintained outside the walls of large psychiatric institutions. The concept of deinstitutionalization, the shifting of patients and comprehensive treatment from large institutions to community settings, was introduced in the late 1950's (Lamb, 1991). The acceleration of deinstitutionalization in the 1980's and 90's has dramatically increased the contact medical-surgical nurses have with mentally ill patients (Canadian Nurses Association, 1991).

With the implementation of the recommendations in Closer to Home (Royal Commission, 1991) mentally ill people will largely be cared for in their own communities and this will further increase the contact nurses have with mentally ill people both in their communities and in hospitals. The Registered Nurses Association of British Columbia (R.N.A.B.C., 1990) further endorses the position that individuals should have access to primary health care as close as possible to where they live. The Royal Commission (1991) emphasizes the need for individual health care providers to be accountable in assessment, support, and follow up of mentally ill patients. The R.N.A.B.C. (1990) endorses nurses as the major provider of primary health care and the first point of contact for health care.

General hospitals in British Columbia admitted approximately 20,000 patients with mental health disorders in the 1989-90 fiscal year (Statistics Canada, 1992). Some of these admissions were for mental illness but others were for a variety of other conditions such as pneumonia, appendicitis, fractures and so forth.

A very complex medical picture is presented by people with mental illness. It is often difficult to interpret physical conditions due to the psychiatric symptomatology, and an existing mental illness is often exacerbated by medical conditions and their treatment. Research suggests that there is a high prevalence of comorbid medical conditions in the mentally ill with undiagnosed physical illness ranging from 43-58% (Barnes, Mason & Greer, 1983).

Socioeconomic status, poor judgment about health needs, lack of motivation and a general tendency by the mentally ill to attach a low priority to physical health place the psychiatric patients at high risk for medical problems. These factors, as well as lack of attention by clinicians to the physical health problems of the mentally ill, appear to contribute to the under-diagnosis of physical health problems among the mentally ill and increases their mortality morbidity rates (Holmberg & Kane, 1995; Liberman, & Coburn, 1986).

Higher rates of undetected physical illness have been found in women with mental illness especially those with bipolar and depressive disorders. As well, men and women with substance abuse and schizophrenia appear to have an increased risk of undetected physical illness (D'Ercole, Skodol, Struening, Curtis & Millman, 1991). Other studies have pointed to the

decreased pain response of schizophrenic patients as a reason for delaying treatment of diseases and complications (Bickerstaff, Harris, Leggett & Keong-Chye, 1988). The differences in recognition and interpretation of physical symptoms by people with mental illness make the assessment and care of these patients very complex.

Nurses are the health care professionals who have the most continuous and intimate contact with patients. The attitudes health care providers possess will have a significant impact on the care and the treatment a patient receives and on the clinical decision making (Roskin, et al., 1986). For these reasons, it is crucial that nurses possess attitudes toward the mentally ill that allow them to provide optimal care in a supportive manner for these patients.

The majority of research found on attitudes of medical-surgical nurses towards mentally ill patients has been conducted either on nursing students or outside the Canadian health care system. Practicing Canadian nurses' perspectives are therefore poorly documented. The purpose of this study is to examine the attitudes of a Canadian sample of medical-surgical nurses towards mentally ill patients.

Problem Statement

Due to the changes in how and where mentally ill patients are treated, medical-surgical nurses are increasingly required to care for and to communicate effectively with patients who are both physically and mentally ill. Nurses often state that they feel unprepared to cope effectively with the problems these patients present (Canadian Nurses Association, 1991) and

express a diversity of opinions and attitudes about caring for mentally ill patients.

The literature suggests that mentally ill patients are sensitive to and influenced by the atmosphere of a hospital unit (Cohen & Struening, 1962). Since the early studies of Cohen and Struening (1962, 1963, 1964, 1965) and those of authors Reznikoff (1963), and Wright & Klein (1966), many changes have occurred. The majority of nurses now have psychiatric experience in their basic education, the treatment of mental illness has evolved and the government has mandated deinstitutionalization. Because these changes could affect nurses' attitudes toward mentally ill patients, more current research is required. Nurses, as the health care professionals with the most patient contact, are largely responsible for creating the atmosphere within a hospital unit. There has been little research on the attitudes of medical-surgical nurses towards mentally ill patients and the factors that affect these attitudes. Further, the factors that influence the care of the mentally ill on medical-surgical units are unknown. It is therefore important to explore and describe these attitudes, identify the factors that may influence attitudes towards mentally ill patients, and describe the factors that influence caring for mentally ill patients on medical-surgical units.

Purpose

The purposes of this study are to (a) describe the attitudes of medical-surgical nurses working in general hospitals towards mentally ill patients, (b) identify factors that affect nurses' caring for mentally ill patients on medical-surgical units, and (c) identify and describe factors that have an influence on the attitudes of medical-surgical nurses towards mentally ill patients.

Conceptual Basis

This study is guided by the Dreyfus model of skill acquisition and Benner's application of this model to nursing practice (Dreyfus & Dreyfus unpublished manuscript, cited in Benner, 1984). The Dreyfus model contends that there are five levels of proficiency: novice, advanced beginner, competent, proficient, and expert. The different levels reflect changes in abilities and performance.

The Dreyfus model outlines three general aspects of skill performance. The first aspect is the movement from reliance on abstract principles to the use of past experience as paradigms. The second aspect is a change in the learner's perception of a situation, in that a situation is seen less as a compilation of equally relevant pieces and more as a complete whole where only certain bits are relevant. The final aspect is the change in the learner's involvement in a situation; the learner no longer stands outside the situation but is now engaged in the situation.

Benner (1984) outlines seven domains of the art and science of nursing. Within each domain, Benner has identified competencies characteristic of an expert nurse. This study will take direction from the first domain, "The Helping Role" (Benner, 1984, p.46). This domain includes such competencies as (a) Presenting: Being with a Patient, (b) The Healing Relationship, and (c) Guiding a Patient Through Emotional and Developmental Change (Benner, 1984, p.50). Each of these competencies requires the nurse to respond to the patient's needs. Benner stated "a deep understanding of the situation is required, and often the ways of being and

copied are transmitted without words but by demonstration, attitudes, and reactions" (1984, p.90).

Through their strong influence on behavior (Kahle, 1984), attitudes will impact on a nurse's ability to perform in the helping role. Attitudes are viewed as among the factors that influence a nurse's ability to become an expert in the competencies of the helping role.

Benner's first domain, the helping role, emphasizes the importance of nurses' attitudes and how these attitudes affect a nurse's ability to assist patients. For nurses to move through the Dreyfus and Dreyfus stages of proficiency and to develop the competencies characteristics of an expert nurse in the helping role, a nurse must possess positive attitudes towards patients. Nurses' attitudes towards mentally ill patients affect their ability to assume the helping role and therefore influence caring for these patients. To care for mentally ill patients at an expert nurse level, attitudes become vitally important. The first step in understanding attitudes is knowing what they are. This study will categorize a sample of medical-surgical nurses' attitudes towards mentally ill patients and attempt to identify the factors that influence these attitudes.

Research Questions

There is little literature on medical-surgical nurses' attitudes towards the mentally ill. In addition, the research found was completed outside of Canada. There were also apparent gaps in the literature such as: (a) the factors affecting care of the mentally ill when hospitalized for medical or surgical illnesses and (b) correlation of such variables as experience with mentally ill patients, personal exposure to the mentally ill, and education, with

the attitudes of nurses. To assist in addressing some of the limitations of the literature this study asks the following questions:

- 1) What are the attitudes of medical-surgical nurses toward the mentally ill?
- 2) What are the factors that nurses describe as influencing their care of mentally ill patients on medical-surgical units?
- 3) What is the relationship between medical-surgical nurses' attitudes towards the mentally ill and selected variables?

Definitions of Terms

For the purposes of this study the following definitions were used:

Attitude: an evaluation of an object based on beliefs, feelings and past behavior (Olson & Zanna, 1993).

Opinion: a verbal expression of attitude (Kahn, 1976).

Attitude Towards Mentally Ill Patients: the positive or negative affect a person has towards mentally ill patients operationalized as scores on the Opinions about Mental Illness questionnaire (Cohen & Struening, 1962) (see Appendix A).

Mentally Ill Patients: individuals whose diagnosis includes a disorder recognized in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994). A disorder found in DSM IV is a generally accepted definition of a mentally ill patient in a psychiatric unit. However, medical-surgical nurses may not be familiar with DSM-IV and likely will have their own definition of a mentally ill patient. As a researcher, I will not know each nurse's definition of a mentally ill patient. Therefore mentally ill patients will include those patients with a DSM IV diagnosis and anyone a nurse views as mentally ill.

Medical-Surgical Nurses: individuals licensed to practice as registered nurses by the Registered Nurses Association of British Columbia (R.N.A.B.C.). These nurses have indicated on their registration form that they work on a regular basis, part-time or full-time, on a medical or surgical unit in a general hospital. These will include nurses working in such specialty areas as palliative care, neurology, orthopedics and so forth.

General Hospital Medical-Surgical Units: acute care facilities in urban and rural British Columbia whose primary function is to treat medical and surgical conditions of adult patients.

Assumptions

Based on the literature related to attitudes, the researcher assumes the following statements to be true:

- Attitudes influence behavior.
- Attitudes are complex and are influenced by many factors.
- Nurses' attitudes may affect patient care.

Based on this study's design, the researcher assumes the following statement to be true:

- The sample is a representation of the population of medical-surgical nurses registered by the R.N.A.B.C.

Limitations

The design of this study limits the generalizability of the findings to the nurses of British Columbia (B.C.). The attitudes of nurses towards the mentally ill in other geographic regions could be influenced by other factors and different variables than those affecting B.C. nurses. The survey design of this research also limits the depth of data collected so that the context of a

nurse's responses will be missing. However the open ended questions allow nurses to comment on some of the factors that may affect their attitudes. The design does not allow for manipulation of independent variables or control of extraneous or intervening variables. Therefore, no clear cause and effect relationship can be determined.

CHAPTER TWO

LITERATURE REVIEW

The literature review is presented in two sections. The first section addresses attitudes, the influence attitudes have on behavior, and the measurement of attitudes. The second section reviews the literature on nurses' attitudes and opinions towards mental illness.

Review of Related Research

Attitudes. The concept of attitude is central to this study. The literature defines attitude in many ways; however, current literature revolves around attitudes being defined in terms of evaluation. Olson and Zanna (1993) define attitude as an evaluation of an object based on beliefs, feelings and past behavior. These theorists also agree that attitudes are represented in memory and have three dimensions: affective, cognitive and behavioral. These same authors further point out that this affective, cognitive, behavioral framework is useful in thinking about the dimensions of an attitude but will not necessarily apply to all attitudes. The influence attitudes have on behavior is the primary reason for this study's focus on attitudes.

The basic rationale for studying attitudes is that they tell us something about probable behavior (Kahle, 1984). The causal relationship between attitudes and behavior is unclear but many authors agree that attitudes strongly influence behaviors (Fishbein & Ajzen, 1975; Kahle, 1984). Wilson and Dunn (1989) contend that persons often lack well-developed reasons for their attitudes and have difficulty explaining behavior in terms of attitudes. At times people are also unaware of the converse: how their attitudes exert an

influence on their behavior (Fazio, 1986). According to Fazio, highly accessible, well-defined attitudes are the most likely to influence behavior. It is clear from these studies that attitudes will affect nurses' behavior.

Researchers continue to study the best method of measuring attitudes. The most common technique for measuring attitudes remains the self-report, with subjects making an evaluative rating of an attitude (Olson & Zanna, 1993). Krosnick and Abelson (1992) stress, however, that the strength of an attitude should be measured as well as the attitude itself. They contend that the influence of an attitude on behavior is related to its strength. These authors agree that the best method of measuring attitudes is through the use of a Likert scale. The Likert scale allows the respondent to attribute strength to the attitude they are expressing such as in the choices among strongly agree, agree, and not sure but probably agree and so forth.

In order to get an accurate measurement of a respondent's attitudes, the researcher must give careful consideration to the instrument used. Olson and Zanna (1993) make the following points about the measurement of attitudes: (a) answers to the current question tend to move in the direction of the preceding answers; (b) the response scale offered to respondents can influence their answers; and (c) relatively minor variations in the wording of questions affect respondent's answers.

In 1962, Cohen and Struening developed and subsequently tested an instrument entitled "Opinions about Mental Illness" (OMI) (Appendix A). Testing of the OMI took place in two Veterans' Administration hospitals in the United States with 1194 hospital personnel completing the questionnaire. The definition of opinions, for the purposes of the present study, is an

expression of one's attitude. Cohen and Struening (1963) considered opinions as a measure of attitude dimensions (p. 111). The five attitude dimensions of their scale are: Authoritarianism, Benevolence, Mental Hygiene Ideology, Social Restrictiveness, and Interpersonal Etiology. These dimensions are described in the Instruments section of this proposal. In 1972, Rabkin described the OMI as complex but the best and only instrument available at that time for measuring opinions about mental illness. The OMI remains the only widely tested instrument to measure nurses' attitudes toward the mentally ill that can be found in the literature. Despite its early origins, the OMI remains the most popular instrument for this purpose as is evidenced by such recent work as that of Wilcox (1987) and Marsey (1987).

Attitudes of Nurses towards Mentally Ill Patients. The following section will describe the research to date on the attitudes that nurses hold towards mentally ill patients. The original research was started in the 1960's and has carried through to the 1990's. This section will conclude with a summary of the demographic variables that researchers have documented as correlating with more positive attitudes towards mentally ill patients.

The attitudes that nurses hold in relation to mentally ill patients will influence the care these patients receive. Cohen and Struening (1962) hypothesized that mentally ill patients are sensitive to and influenced by the attitudes of hospital personnel. These authors researched hospital personnel to describe their attitudes and define what variables influence their attitudes. The studies of Cohen and Struening (1962, 1963, 1964, 1965), documented the attitudes of hospital personnel and concluded that professional training produced more positive attitudes (i.e., low authoritarian, and more benevolent

attitudes towards mental illness). Other studies validated Cohen and Struening's findings (Reznikoff, 1963; Roskin et al., 1986; Wright & Klein, 1966). These authors generally found professional staff more accepting of mental illness than other employees with less training.

The effect of education, experience and other demographic information on nurses' attitudes toward mental illness is documented in a study by Wilcox (1987). Wilcox (1987) measured attitudes of nurses using the OMI and correlated these data with demographic variables. One hundred general hospital medical-surgical nurses comprised the sample. Forty-four of these nurses held a B.S.N. degree, thirty-one an Associate degree, four a Master's degrees and twenty-five were Licensed Vocational Nurses. The study had a pre-post test design with nurses being given the OMI twice with a fourteen day separation in administration. Fifty of the one hundred nurses attended a two hour inservice session and received ongoing support from mental health clinicians in caring for mentally ill patients. On follow up, these nurses' attitudes became less authoritarian and less restrictive in their view of treatment. Unfortunately, assignment of the subjects to the control and experimental groups was not random, and therefore some basic differences in motivation and amenability to attitude change could account for this positive finding.

Wilcox (1987) found that attitudes, as measured by the OMI, can be altered by exposure to very basic types of psychiatric principles. The results indicated that personal exposure to mentally ill patients was the strongest influencing factor in determining positive attitudes towards the mentally ill. Nurses with increased exposure in school to mentally ill patients

demonstrated less authoritarian beliefs on pre-test. However, this relationship did not apply to the Social Restrictiveness Scale. This finding contrasts with Cohen and Struening's (1965) finding of a high correlation between the Authoritarian and Social Restrictiveness dimensions.

In an attempt to confirm that education and exposure to mentally ill patients positively affects attitudes, Roskin et al. (1986) conducted a study of 69 medical students before and after a six week psychiatric internship. Using a modified version of the OMI, Roskin et al. analyzed medical students' attitudes toward psychiatric illness, the doctor-patient relationship and general attitudes toward various patient types. The males in this study were more prone to view mental illness as a moral weakness and had a tendency to need more control over patients than the females who were more comfortable with the patients' autonomy. Generally, they found that students were more positive toward mentally ill patients and able to relate more closely to these patients following the internship. These findings are significant but must be viewed with caution as the control group was only 17 students, 14 males and three females. Despite this limitation, these findings appear to confirm that education and exposure to mentally ill patients produces more positive attitudes toward the mentally ill (Roskin et al, 1986).

As a follow up to the first Roskin et al. study, another more extensive study examined the attitudes of nurses, along with a variety of other health care professionals toward mental illness (1988). Using a modified version of their first questionnaires, they asked a total of 377 health care professionals from one hospital to respond to mailed questionnaires. The findings indicated that, of all the professions, nurses scored the highest in viewing mental illness

as organic in its etiology. Nurses also scored highest on the distancing-detachment factor and lowest on the nurturant-empathic factor. The authors found these findings surprising, and explained them by describing nurses as often burned out as they are required to spend so much more time with patients compared with other professionals. Roskin et al. determined that most of their findings could be accounted for by personality characteristics of the individuals in a given field, education, clinical experience within disciplines and the types of individuals that are attracted to each profession. These studies indicate the need for further research to determine if these findings remain constant when nurses from a variety of hospitals and a wider geographical region are surveyed.

In an attempt to describe the attitudes of the health care providers working with long term psychiatric patients, two British researchers, Scott and Phillip (1985) conducted a study using the Attitudes to Treatment Questionnaire (ATQ). The questionnaire measures two factors. The emphasis of factor one is physical treatments, need for good hygiene, strict ward discipline and the image of staff as the authority. Factor two stresses the importance of psychological closeness between staff and patients, and the therapeutic value of honest non-professional communication contrasted with the traditional doctor-patient relationship. Their sample consisted of 161 female and 38 male registered mental health nurses, nursing students and nursing assistants. These authors found that the most statistically significant indicator of attitude is education. Staff with more education and training have significantly more positive attitudes. The groups with less education favored impersonal, formal relationships with patients and preferred physical methods

of treatment. These findings concur with Cohen and Struening's (1965) who found that hospital personnel with lower status were more authoritarian and restrictive in their attitudes towards mentally ill patients.

Scott and Phillip (1985) also found that staff under the age of 30 were less authoritarian and impersonal in their relationships with patients than those over 45 years old. Males and females differed in their approach to patients. Female staff preferred physical methods of treatment and were more authoritarian and impersonal towards patients than males. Females tended to maintain a greater psychological distance and the authors hypothesized that these nurses followed the traditional general hospital nurse manner. More research is indicated to compare these finding with the attitudes of general hospital nurses toward mentally ill patients.

Weller and Grunes (1988) developed a 24 item questionnaire entitled "Attitudes towards Mental Illness" (AMI) to test the hypothesis that contact and the opportunity to become acquainted with mentally ill patients will increase mutual understanding and thus result in a more positive attitude. The sample consisted of 95 Israeli female RNs and LPNs divided into three groups based on contact with mentally ill patients. The maximum contact group consisted of nurses working in a hospital for the mentally ill. Nurses working on medical-surgical units in a general hospital where mentally ill patients went for medical treatment comprised the medium contact group. The no contact group consisted of nurses working in a general hospital with no contact with the mentally ill. The results of this study indicate that contact with mentally ill patients did not influence attitudes towards the mentally ill either positively or negatively. Weller and Grunes also found that LPNs held a significantly more

positive attitude towards mentally ill patients than did the RNs. Weller and Grunes explain this disparity by noting that Israeli RNs have a supervisory role and little contact with mentally ill patients. Caution must be used in interpreting Weller and Grunes' findings as they failed to report the AMI instrument's validity and reliability results with their findings. As well, the subjects within Weller and Grunes' study were not randomly selected, were from three intact groups and all were from one religious affiliation.

Several authors have documented that, with experience and knowledge, students' attitudes toward mental illness can change in a positive direction (Costin & Kerr, 1962; Landeen, Byrne & Brown, 1992; Marsey, 1987; Meyer, 1973; Swain, 1973). Meyer, using the OMI, documented that medical-surgical nursing students exhibited more authoritarian attitudes and were less psychologically minded than psychiatric nursing students. She also found that nurses with increased experience in psychiatric nursing exhibited significantly more benevolent attitudes towards mental illness. This finding is inconsistent with Kahn (1976) who found no difference between psychiatric nurses and other types of nurses with regard to benevolence. Marsey (1987) also documented that positive attitudes, which he hypothesized developed during psychiatric training, endured over time.

In summary, the variables that researchers have documented as correlating with more positive attitudes are (a) personal experience with a mentally ill person, (b) professional training, (c) education concerning mental illness, and (d) professional experience with mentally ill patients. In reviewing the literature, conflicting findings were found. The studies differed in the variables they identified as correlating with positive attitudes. The studies

speculated on the factors that influence care of the mentally ill, however none of the studies attempted to document nurses' perceptions of the factors influencing care of the mentally ill.

This scarcity of definitive research suggests the need for further study into the attitudes and factors that influence nurses' attitudes. In addition, the majority of research found was done outside of Canada. The Canadian health care system and socio-cultural climate are fundamentally different than other countries and may influence findings. More research is required to develop an understanding of what attitudes nurses hold towards mentally ill patients and what factors influence these attitudes. It is also clear that more attention to the factors that influence nurses caring for mentally ill patients is warranted.

CHAPTER THREE

METHODS

Presented in this section is a description of the research design and the instruments that were used. The second section outlines the data collection procedures, analysis procedures, and the human rights considerations. Lastly, the sample response, demographics, and their education and personal experience with mentally ill patients are described.

Research Design

This study uses a descriptive survey design. A descriptive design aims to describe the current state of the phenomena of interest, namely nurses' attitudes and the factors affecting their care of mentally ill patients. The descriptive study aims to describe relationships among variables as opposed to identifying cause and effect (Polit & Hungler, 1991). Survey research was chosen for its advantage of being able to cover a broad scope (Polit & Hungler, 1991). These aims are consistent with the purposes of describing relationships among demographic data and nurses' attitudes, and identification of the factors that might influence the care of mentally ill patients on medical-surgical units.

Instruments

Opinions About Mental Illness. The Opinions About Mental Illness Scale (OMI) was used to determine nurses' attitudes towards mental illness. The OMI was selected over the Attitude towards Mental Illness questionnaire (AMI) due to its established reliability and validity over time. The OMI was developed by Cohen and Struening (1962) from 200 opinion

items referring to cause, description, treatment and prognosis of severe mental illness. Experts edited the list down to 55 opinion items. These were then supplemented by opinion items from the Custodian Mental Illness Ideology (CMI) scale developed by Gilbert and Levinson in 1956 and the California F scale developed by Struening in 1957. The result was the development of a 70 item opinion tool. Through factor analysis, five independent factors were identified. Scales were then developed from the 70 opinion items to measure the five factors. The result was a 51 item opinion questionnaire. The OMI provides scores on each of the five subscales for each respondent. The subscales are defined as follows:

- A) Authoritarianism: a view of the mentally ill as an inferior class requiring coercive handling.
- B) Benevolence: a kindly, paternalistic view toward patients based upon religion and humanism rather than science.
- C) Mental Hygiene Ideology: a view of mental illness as an illness like any other, a medical model adapted to psychiatric problems focusing on individual maladaptation.
- D) Social Restrictiveness: a view of mental patients as a threat to society, particularly to the family, and therefore should be restricted both during and after hospitalization.
- E) Interpersonal Etiology: a view of mental illness as arising from interpersonal experience especially deprivation of love during childhood.

The OMI instrument was then tested in two Veteran Administration hospitals (N=1194). Table one presents the validity and reliability statistics collated from the 1962 initial study.

Table 1

Kuder-Richardson Formula 20 reliability coefficients and Thomson's pooling square validity coefficients (Cohen & Struening, 1962 p.355-56).

Factor	A	B	C	D	E
Reliability (KD-20)	.82	.62	.61	.23	.60
Validity	.89	.76	.65	.67	.78

Factor D, Social Restrictiveness, had the lowest reliability coefficient at .23. Cohen and Struening deemed this satisfactory in light of Factor D's higher validity coefficient and significant demographic correlation. The remaining factors were viewed as "quite satisfactory for group comparisons" (Cohen & Struening, 1962 p.355). The factors are mutually independent, however, the factor scores show some weak correlation. Authoritarianism (Factor A) is weakly linked with Social Restrictiveness (Factor D) with a correlation of .22. Benevolence (Factor B) and Mental Hygiene Ideology (Factor C) are correlated at .11. Interpersonal Etiology (Factor E) was found to have a correlation with Mental Hygiene Ideology (Factor C) of .24. Cohen and Struening, (1962) found that a score on any one factor was not a predictor for another factor's score. Dr. Struening who holds the copyright on the OMI, granted permission to use the OMI, copies of the OMI instrument, a scale composition, and score criteria for the OMI (Appendix E).

Following the initial study, Cohen and Struening used the OMI to determine the attitudes of hospital personnel in 12 VA hospitals and with the general public (N=8248). In one of Cohen and Struening's last studies

(1965), the OMI was used with hospital employees (N=4784). The results divided the employees into eight occupational groupings based on their attitudes as recorded by the OMI. The OMI has subsequently been used in a number of studies and remains in wide use today.

General Questionnaire. The general questionnaire (Appendix D) provided data to answer research questions 2 and 3 and is composed of three sections. The first section covers basic information such as gender, age, race and marital status. The second section asked the respondent for information on level of education, area of clinical work, and exposure to psychiatry. The final section consisted of open ended questions on factors that the respondents think influence their care of mentally ill patients on medical-surgical units. The general questions were developed by the investigator based on a literature review of variables that may influence attitudes and in discussion with a panel of nurse experts from nursing education and practice.

Procedure

Sample. A sample of 250 subjects was drawn from nurses registered with the Registered Nurses Association of British Columbia. The sample group was formed from a computer generated random selection of nurses who indicated on their registration form that they work on a regular basis on a medical or surgical unit in a general hospital. The sample included nurses throughout British Columbia. This sampling configuration was chosen to obtain a wide range of opinions and to encompass nurses from diverse exposures to mentally ill patients. Participants were selected using the following inclusion criteria:

- 1) The nurse is registered with the Registered Nurses Association of British Columbia (R.N.A.B.C.).
- 2) The nurse is currently working on a regular basis either part or full time on a medical or surgical unit in a British Columbia Hospital.

Data Collection. Data were collected by a mail survey. The research proposal received approval from the thesis committee, the University of British Columbia Behavioral Sciences Screening Committee for Research and Other Studies Involving Human Subjects, and the R.N.A.B.C. prior to data collection.

The R.N.A.B.C. was requested to computer generate a random list of 250 nurses who meet the inclusion criteria and produce mailing labels for each subject. The number of questionnaires mailed allows for a return rate between 45- 50% with a resulting sample size of 112-126 nurses. According to Polit and Hungler (1991) a sample size of 112-126 produces a power of .75-.80 using a medium effect size of .25, and a significance level of alpha 0.5. Two hundred and fifty coded packets containing an information letter (Appendix B), a questionnaire (Appendix D), the OMI instrument (Appendix A), and a stamped, self-addressed envelope were delivered to the R.N.A.B.C. Each packet was affixed with an address label and then mailed by the R.N.A.B.C. The R.N.A.B.C. retained the generated list which ensured anonymity of the nurses. The respondent was asked to complete the OMI and demographic questionnaire and return both to the researcher in the stamped self-addressed envelope provided.

Data Analysis. The data were analyzed using univariate

descriptive statistics and correlational procedures. This plan for data analysis is congruent with the descriptive survey approach. The goal was to describe nurses' attitudes and the factors affecting these attitudes and not to infer any cause and effect relationship among the variables explored.

Descriptive statistics were used to determine modes, medians, means, and standard deviations for all general and OMI questionnaire results. Using the product-moment correlation coefficient (Pearson's r) the interval and ratio demographic data were correlated with the scores on the OMI subscales. This procedure is appropriate with variables measured on either an interval or ratio scale (Polit & Hungler, 1991). The data from the questionnaires were coded and analyzed using the personal computer program Microsoft Excel.

The open ended questions at the end of the general questionnaire were summarized and used to identify the factors nurses feel influence caring for mentally ill patients in medical-surgical areas. These factors are reported in a descriptive manner.

Results of this study need to be interpreted with caution as the sample size was small ($n=113$) and represented only 1.8% of the target population. The random sample design helped produce a representative sample of the target population and generated data reflecting a wide variety of attitudes. However, some bias could still exist on the part of the responder as opposed to the non responder. For example, the responder could have more interest in or frustration about the care of the mentally ill than the non responder. This interest in mentally ill people on the part of the responder could have an influence on their attitudes and therefore the outcomes of this study.

The survey design of this study also limits the depth of the data collected so that the full context of a nurse's responses is missing. The design also does not allow for manipulation of independent variables or control of extraneous or intervening variables. Therefore no clear cause and effect relationship can be determined.

Human Rights and Ethical Considerations

The sampling design ensured complete confidentiality and anonymity for all respondents. The introductory letter clearly outlined the study purposes, stated that participation is voluntary and that return of the questionnaire indicates consent to participate in the study (Appendix B). Participants were informed that there is no penalty for refusal to participate. The findings presented group data only and no identifying information was requested. Prior to data collection, the study was granted approval from the University of British Columbia Behavioral Sciences Screening Committee for Research and Other Studies Involving Human Subjects (Appendix C).

Sample Characteristics

Sample Response. Of the 250 questionnaires mailed, 121 were returned completed (48%). Two of the returned questionnaires were missing large amounts of data and were therefore excluded. Six of the returned questionnaires did not meet the criteria of working full or part-time on a medical or surgical unit in a general hospital and were eliminated. Of the six, three were presently working in nursing education and three were working in administration, home care and a doctor's office. Nurses working casual on medical or surgical units were included and classified as working part-time as they had ongoing contact with patients on medical or surgical units. The final

number of usable questionnaires was 113. This return rate resulted in a power of .76 assuming an alpha of .05 and a medium effect of .25.

Sample Demographics. Tables two and three present the demographics collected on the sample which consisted of gender, marital status, race, age, highest level of nursing education, areas of work, size of city/town working in, and work experience information. The majority of the sample were female (95.6%), married (68.1%), and Caucasian (91.2%). Their mean age was 38. Eighty two percent of the nurses were prepared at the diploma level (82.3%) with only 16.8% at the baccalaureate level. One nurse had a diploma in psychiatric nursing as well as general nursing. Forty six percent of the nurses worked part-time and fifty three percent worked full-time in medical or surgical areas. Forty seven percent worked in a combination of medical-surgical nursing, fifty three percent worked in medical areas exclusively and thirty percent worked in surgical areas exclusively. The majority of the nurses worked in urban areas (81.4%) and had a wide range of nursing experience (1.1 to 36 years) with a mean length of nursing experience of 13 years.

Education and Personal Experience with Mentally Ill Patients.

The nurses were asked whether they had psychiatric clinical experience in their education, inservices or training on caring for mentally ill patients, worked in a mental health or psychiatric setting, or had personal experience with individuals diagnosed with a mental illness. Table four presents this data. The majority of the respondents had psychiatric clinical experience in their education (88.5%) and no further inservices or educational training (64.6%).

Table 2

Demographic Characteristics of Respondents (Categorical Variables)

Variable	Response	Frequency	Percent
Gender	Male	5	4.4%
	Female	108	95.6%
Marital Status	Single	16	14.2%
	Married	77	68.1%
	Divorced	11	9.7%
	Other	9	8.0%
Race	Caucasian	103	91.2%
	Oriental	6	5.3%
	Black	2	1.8%
	Other	2	1.8%
Nursing Education	Diploma	93	82.3%
	Baccalaureate	19	16.8%
	Masters	1	0.9%
Clinical Area	Medical	27	23.9%
	Surgical	33	29.2%
	Medical/Surgical	53	46.9%
Population of City/Town	Less than 10,000	17	35.5%
	10,000-50,000	4	15.0%
	More than 50,000	92	81.4%
Present Job	Part-Time	53	46.9%
	Full-Time	60	53.1%

Table 3

Demographic Characteristics of Respondents (Continuous Variables)

Variable	Range	Mean	Standard Deviation
Age	22-64	38	8.9
Years Practicing Nursing	1.1-36	13	8.7

Only 19.5% had ever worked in a mental health or psychiatric setting.

Approximately one-half (55.8%) of the nurses had a personal experience with individuals diagnosed with a mental illness such as a friend, relative or self.

Table 4

Education and Personal Experience with Mentally Ill Patients

Variable	Response	Frequency	Percent
Psychiatric Clinical Experience in Education	Yes	100	88.5%
	No	13	11.5%
Work in Mental Health or Psychiatric Setting	Yes	22	19.5%
	No	91	80.5%
Inservices or Educational Training in Care of Mentally Ill	Yes	40	35.4%
	No	73	64.6%
Personal Experience with Mentally Ill	Yes	63	55.8%
	No	50	44.2%

CHAPTER FOUR

PRESENTATION OF RESULTS

The first research question will be answered by results of the OMI which describes nurses' attitudes towards mentally ill patients. The second question will be answered by reporting the factors that nurses describe as influencing their care of mentally ill patients on medical-surgical units. To answer the third question, results are outlined which describe the relationship between medical-surgical nurses' attitudes towards the mentally ill and selected variables such as personal experience with individuals diagnosed with a mental illness, highest level of nursing education, years of nursing experience, and so forth. Finally, additional findings will be noted.

Research Question 1:

Nurses Attitudes Towards Mentally Ill Patients.

Nurses' attitudes towards mentally ill patients were measured using the 51 question OMI. Scores for each of the five OMI subscales are presented in Table five. Data indicating the respondents attitudes towards mentally ill people were calculated using the Cohen and Struening (1963) scoring guide for the OMI. Higher scores indicate agreement with the defined subscale while lower numbers represent disagreement with the factor. To retain questionnaires that were missing one to two responses, the missing items were replaced with the median for that item. Using the median for an item is unlikely to skew the results (Tabachnick & Fidell, 1989).

Table 5

OMI Questionnaire: Range, Mean and Standard Deviations

Factor	Range	Mean	Standard Deviation
Authoritarianism	3-31	13.7	5.3
Benevolence	33-64	48.3	5.4
Mental Hygiene Ideology	17-40	28.8	4.1
Social Restrictiveness	2-31	15.3	5.5
Interpersonal Etiology	1-21	9.4	4.2

A high score on the first subscale, authoritarianism, indicates a view of the mentally ill as an inferior class requiring coercive handling. Lower scores represent disagreement with this view. Scores reveal a normal distribution with a mean of 13.7, a range of 3 to 31, and a standard deviation of 5.3. The maximum possible score was 56. This relatively low mean indicates a more positive and liberal attitude towards the mentally ill.

Higher scores on the second subscale, benevolence, indicate a kindly, paternalistic view of the mentally ill while acknowledging some fear of the mentally ill. Benevolence has its roots in humanism and religion rather than science. Scores were normally distributed with a range of 33 to 64, a mean of 48.3, and standard deviation of 5.4. The possible range of scores for this subscale was negative 4 to 66. This is a higher mean than in previous studies, indicating that nurses in this study have some fear of mentally ill patients while viewing them in a paternalistic manner.

The third subscale, mental hygiene ideology, views mental illness as an illness like any other, adapting the medical model to psychiatric problems and focusing on individual maladaptation. Higher scores therefore indicate adherence to the application of the medical model to psychiatry. Scores were normally distributed with a range of 17 to 40, a mean of 28.8 and a standard deviation of 4.1. The highest possible score on this subscale is 46. Nurses in this sample had a relatively low mean on this factor, indicating that they view mental illness as different from a medical disease.

The fourth subscale, social restrictiveness, reflects a central belief that mental patients are a threat to society, particularly to the family, and therefore should be restricted both during and after hospitalization. Higher scores indicate a fear of the mentally ill and the need to restrict these people. Scores were normally distributed with a range of 2 to 31, a mean of 15.3 and a standard deviation of 5.5. The highest possible score on this factor is 51. This comparatively low mean indicates an acceptance of mentally ill people in society.

The last subscale, interpersonal etiology, views mental illness as arising from interpersonal experience, especially deprivation of love during childhood. Higher scores indicate an adherence to an interpersonal etiology as opposed to a biochemical or genetic cause of mental illness. Scores were normally distributed with a range of 1 to 21, a mean of 9.4 and a standard deviation of 4.2. The highest possible score on this scale is 36. The relatively low mean on this factor indicates an acceptance of a biological cause of mental illness.

In comparing these data with those originally obtained by Cohen and Struening (1962) in two Veterans hospitals, scores for factors A, C, D and E are quite a bit lower than those of the nurses in the original study (see Table 6). The nurses' scores for the original study were 16.5, 45.5, 36.5, 20.5 and 20.1 for factors A, B, C, D and E respectively. Only factor B, benevolence, has an increased score over the original study. These higher scores in the original study indicate a more authoritarian attitude towards the mentally ill with a greater adherence to a view of mental illness as an illness like any medical disease. Scores in the original study also indicate more of an opinion that mentally ill patients are a threat to society and that the cause of mental illness arise from interpersonal experiences. This difference in scores suggests a difference in the two populations and possibly a difference in general attitudes over time.

Table 6

Comparison of OMI Mean Results

Factor	Nurses in Present Study	Nurses in Cohen and Struening 1962 study
Authoritarianism	13.7	16.5
Benevolence	48.3	45.5
Mental Hygiene Ideology	28.8	36.5
Social Restrictiveness	15.3	20.5
Interpersonal Etiology	9.4	20.1

Research Question 2:**Factors Affecting Respondents Care of Mentally Ill Patients.**

Responses to the open ended questions at the end of the general questionnaire were categorized to summarize the factors nurses feel influence caring for mentally ill patients in medical-surgical areas. The first question asked the respondents to identify any factors that affected their ability to care for mentally ill patients in their present work environment. Eighty two (72.6%) of the total respondents answered this question. The second open ended question gave nurses an opportunity to add any other comments they wished regarding the care of mentally ill patients in medical-surgical settings. Fifty eight of the total respondents (51.3%) made comments under this section. Factors that nurses identified and the percentage of responses are summarized in Table seven. The majority of the respondents (70.7%) reported that lack of time and staff/patient ratios affected their ability to care for mentally ill patients. The following quotes are characteristic of the comments made by the nurses regarding the lack of time to care for mentally ill patients. "Most nurses want to interact therapeutically but are limited by time they have so much to do in so little time." "Our ward has critically ill and heavy medical pts. We 'fill' in our empty beds with psych pts. They get very little nsg care due to the heavy workload."¹

¹ Abbreviations have been retained to preserve the style of nursing dialogue.

Table 7

Factors Affecting Care of the Mentally Ill

Factor	Percent
Lack of Time - Nurse Patient Ratio	70.7%
Lack of Knowledge/Experience	58.5%
Physical Layout of Unit	15.9%
Lack of Support	13.4%
Attitude Towards Mentally Ill	13.4%
Fear	12.2%
Expertise of Doctor in Charge	7.3%
Past Training with Mentally Ill	6.1%
Fear of Other Patients	4.9%
Safety of Mentally Ill Patients	4.9%

Many nurses expressed their frustration at not having time for these patients as is depicted in the following quote. "Do not have the time to give to these patients - which may even make it worse for them i.e. the feeling that people don't care or can't be bothered. Very frustrating when there is no time." One nurse expressed her thoughts and feelings in the following way:

Nurses are presently forced to give only cursory care to patients due to increased workload, increased pt acuity, decreased staffing. To care for the mentally ill who happen to have physical disease processes in place is difficult. We have less time to do our work (assess, plan, implement) and no help to call on to do that work.

The second most common factor that respondents identified as interfering with caring for mentally ill patients was a lack of knowledge and experience with mental illness (58.5%). As illustrated in the following quote, nurses felt they did not know enough about mental illness and particularly how to care for people who are mentally ill. "Many nurses lack anything more than a cursory knowledge of psychiatry illness and what a psychiatric patient's treatment regime should look like." This lack of knowledge included a lack of communication skills, psychiatric drug knowledge, an ability to care for anxious and noncompliant patients, and so forth. The following quotation depicts a nurse's lack of knowledge regarding psychiatric drugs and the need for more education: "nurses do not know how to medicate, and when to use PRN's for mental health pts. . . . RN's do not get enough training in this area in our 'general' programs." A few respondents commented on the need for good communication skills and a non-threatening approach in caring for mentally ill patients.

The next most common factor that respondents identified as interfering with caring for mentally ill patients was the physical layout of units (15.9%). Nurses cited the lack of privacy and security measures in medical-surgical units as factors in caring for mentally ill clients. Nurses also found that there was a lack of support by other health care workers (13.4%) in prescribing and implementing appropriate care for mentally ill clients.

Nurses felt the attitudes people hold towards working with mentally ill clients interfered with caring for these people as patients (13.4%). The following quotation depicts the feeling of one nurse about caring for mentally ill clients: "I find it difficult working with mentally ill patients. The empathy is

there, but not the patience. I find dealing with these types of patients upsetting." Nurses also felt that fear of mentally ill clients was a factor in caring for these patients (12.2%). They made statements such as "I'm nervous around psychotic patients", I feel "at first fear, not really anything else" and "when it says 'psyc history or mental illness' on the persons diagnosis most nurses get 'scared'."

Another factor that nurses felt affected their ability to care for mentally ill patients was the expertise of the doctor in charge of the patient's care (7.3%). Nurses commented on their lack of autonomy in referring patients to psychiatry as illustrated by the following quotation.

The necessity of a Drs. order to consult psychiatry when mentally ill pts. are admitted - why should it be the Drs. decision when we are the one's spending so much time with them - when we don't have any knowledge re: a particular mental illness, who better to consult with then psychiatry re: the pts. trtmt of his/her mental illness.

Nurses felt that their lack of experience with mentally ill clients (6.1%) influenced their ability to care for these patients. The following quote represents the comments made in this area. "I don't have any specific clinical experience other than that acquired during educational training." Nurses also emphasized their lack of knowledge regarding how to care for mentally ill clients as illustrated in the following quotation.

Nurses in these settings, I feel, do not have the knowledge to give these pts. proper mental care. The pts. is ignored or laughed about back at the nsg. station. This usually occurs when the pt. is delusional. I have never seen this with depression. Depression is almost easier to

deal with because most nurses, themselves have experienced it in varying degrees.

Another concern was for other patients who are sometimes fearful of mentally ill clients (4.9%). As one nurse said, the "busy surgical ward is no place for mentally ill pts. Cannot spend enough time with them and are disruptive at times for the surgically ill pts and very upsetting for the ill pts." Other nurses expressed differing feelings as in the following quotation.

Having mentally ill pts on surgical ward is often very stressful for other pts. on the ward. These surgical pts are feeling physically threatened at times, or have to listen to inappropriate verbalization at a time when they feel they cannot protect themselves. They have less understanding, usually, of mental illness than nursing staff, and even nursing staff (with only basic psych training) are frightened at times.

The last factor that nurses identified as influencing their care of mentally ill clients was the safety of these clients and the nurses' inability to keep track of these patients (4.9%). The following quote is representative of the comments made regarding this factor. "Unless we have extra staff for that pt. we can't always keep track of them." Nurses also expressed their thoughts regarding the appropriateness of mentally ill patients on medical-surgical units as in the following response.

Acutely psychotic patients do not belong on a general hospital ward, particularly if they are likely to act out violently. The most disruptive individuals appears to be those who are both chemically dependent and psychologically disturbed. At times 2-3 staff members have been

involved in their care; the other patients get neglected during these acute episodes.

Other factors that nurses elaborated on, especially in the second open ended question, covered a wide scope from reinforcement of the factors that nurses felt influenced their care, and recommendations for improvement of care on medical-surgical wards to the need for more education and inservice for nurses on the care of mentally ill clients.

Typical comments depicted nurses' feelings about mentally ill clients on medical-surgical units. One nurse wrote "unfortunately the mentally ill seem to be ignored or misunderstood in the surgical setting as staff has neither time nor knowledge of mental illness to care for these pts. properly."

The need for more extensive basic education in psychiatry was highlighted as seen in the following quote. "RN programs do not cover enough information re caring for mentally ill. RN's are afraid of pts., or ignore pts. due to lack of knowledge." Nurses also commented on the need for more knowledge and suggested inservice education. "All nurses should have inservice about how to care for mentally ill pts. especially [when] it happens in old adult population in acute care setting."

One nurse commented on how mentally ill patients recovered in hospitals by stating the following. "Unfortunately the 'medical or surgical' problem gets dealt with but the mental illness gets ignored and depending on a patients stay can really mix up and regress these patients in their pre-admission mental status!"

In summary, nurses felt that a lack of time to properly care for mentally ill patients was a major factor in caring for mentally ill patients on medical-

surgical units. Lack of knowledge and experience with mentally ill patients was another major factor that nurses felt hampered their ability to care for mentally ill patients. Other significant factors that nurses commented on were the physical layout of the unit, a lack of support, the attitude of other health care workers, and a fear of mentally ill patients.

Research Question 3:

Relationship of Variables to Attitudes Towards the Mentally Ill.

The correlation of OMI scores with answers on the general questionnaire provided data on the relationship between variables to nurses' attitudes. Table eight presents the five OMI factors correlated with selected variables using the Pearson r procedure. Findings indicate a weak correlation between female gender and Benevolent attitudes (Factor B) but it must be remembered that the sample size of males is very small. The other weak correlation was between nurses working in surgical areas and authoritarian attitudes (Factor A). A significant negative relationship was found between education and the nurse's belief in social restrictiveness (Factor D). In other words, more education correlates with a belief that mentally ill patients are not a threat to society and do not need unnecessary restrictions put on their lives. A lack of inservice or other training on care of the mentally ill correlated with a belief that the mentally ill are a threat to society and should have restrictions put on their lives (Factor D). Lack of inservice or other training also correlated significantly with a belief that mental illness arises from interpersonal experiences, especially deprivation of love during childhood (Factor E). Analysis did not indicate any other significant correlations between variables and the factors of the OMI.

Table 8

Relationship of Variables to Attitudes Towards the Mentally Ill

Factor	A	B	C	D	E
Gender: Female vs Male	-0.072	0.191*	-0.134	0.043	-0.149
Age	0.090	-0.055	0.133	0.048	0.146
Education	-0.155	0.139	0.096	-0.217*	-0.025
Work Area: Surgical vs Medical	0.191*	-0.087	-0.050	0.165	0.090
City/Town Size	-0.140	0.095	0.039	-0.069	-0.094
Years of Practice	0.094	0.035	0.033	0.107	0.138
Full Time vs Part Time	-0.045	0.025	0.071	0.059	-0.015
No Psychiatric Clinical in Education	-0.007	-0.057	-0.013	-0.025	0.097
No Work in Psychiatry	0.018	-0.176	0.068	-0.008	-0.002
No Inservice Training	0.161	-0.173	-0.110	0.197*	0.216*
No Personal Experience	0.063	0.008	-0.078	0.157	-0.046

Note. * significant findings. $r=.182$ for a two-tailed test assuming a significance level of alpha 0.5 with $df=111$.

Additional Findings

In review of the general questionnaire, nine (8%) of the respondents included unsolicited comments regarding the OMI tool. The comments were diverse and ranged from questions about particular OMI items to general

statements about the tool's relevancy. One nurse questioned the wording and generalization of mental illness on the OMI:

I disliked some of the wording in the questionnaire e.g. question #1; what does it mean 'work too hard'? Question #5; what does it mean 'if parents loved their children more'?, etc. also, there are many different types of mental illness, questionnaire required one to generalize them all as one category.

Some nurses questioned specific OMI items as depicted in the following example; "In the question you ask if they are dangerous. It would have been helpful to know to whom. Society or themselves." Another nurse commented on the OMI in stating "I found the design of this questionnaire poor - reflecting a largely genetic bias towards etiology. Also mental illness is not defined well." The currency of the OMI tool was questioned by one nurse in the following comment. "Is this current? The questions seem very dated - at a level of maybe 20 or 30 years ago when people's ignorance was greater (I would hope so) than today! I was surprised by many of the questions." These quotes are representative of the comments made on the OMI.

CHAPTER FIVE

DISCUSSION OF RESULTS

The results will be discussed in four sections: sample characteristics, attitudes of nurses towards the mentally ill, relationship of variables to attitudes towards the mentally ill, factors that influence care of the mentally ill, and the OMI tool. This chapter will conclude with a summary of the findings.

Comparison of the Sample to the Population

The sample in this study represents the population of nurses in British Columbia working on medical-surgical units in general acute care hospitals. At the time of this study, the total number of nurses employed full or part time in general hospitals on medical-surgical units in British Columbia was 6,262 (C. Kermacks, Director Regulatory Services at R.N.A.B.C., personal communication, July 9 1996). A random sample of 250 nurses, representing 4% of the target population, was mailed questionnaires. One hundred and thirteen usable questionnaires resulted, representing 1.8% of the target population. The sample does not vary significantly from the target population on the variables of age, gender, education and type of employment (C. Kermacks, Director Regulatory Services at R.N.A.B.C., personal communication, July 9 1996) as illustrated in Table nine.

Attitudes of Nurses Towards the Mentally Ill

Comparison of this study's OMI scores was restricted to previous studies that had used the 51 question OMI and had published the factor means. This study was compared to the one Cohen and Struening study (1962) that reported OMI means and the Wilcox study (1987).

Table 9

Comparison of Sample to Population of British Columbia Nurses

Characteristics	Sample	Population
Age Range	22-64	1.3% < 25 to 12.5% >54
Gender		
Male	4.4%	3.3%
Female	95.6%	96.7%
Education		
Diploma	82.3%	79.4%
Baccalaureate	16.8%	18.9%
Masters	0.9%	1.6%
Present Work		
Full Time	53.1%	51.1%
Part Time	46.9%	40.5%

The lower means reported on Social Restrictiveness and Interpersonal Etiology, and the higher means reported on Benevolence (see Table 10) seem to indicate a trend over time towards a more positive and liberal attitude towards the mentally ill. Lower scores on Mental Hygiene Ideology may represent a shift away from seeing mental illness as a medical problem like any other. It is puzzling that Authoritarianism is the only factor that does not appear to show any kind of trend over time. The Wilcox study shows an increase in Authoritarianism while this study indicates a lower mean for Authoritarianism than either of the earlier studies.

Table 10

Comparison to Previous Studies

Factor	Cohen and Struening, 1962	Wilcox, 1987	Present, 1996
Authoritarianism	16.5	19.1	13.7
Benevolence	45.5	46.6	48.3
Mental Hygiene Ideology	36.5	29.5	28.8
Social Restrictiveness	20.5	18.4	15.3
Interpersonal Etiology	20.1	14.4	9.4

One possible explanation for the more positive attitudes is changes in society's attitudes and treatment of the mentally ill from the 1960's to the 1990's. The late 1980's and early 1990's have seen large public awareness campaigns on mental health issues. Specifically, public awareness campaigns on depression and schizophrenia have occurred in British Columbia. Public discussion about the care of the mentally ill has raised the profile of mental illness in British Columbia. The provincial Mental Health Act recently came under scrutiny and is now in review as it is believed to be inconsistent with the Canadian Charter of Rights and Freedoms (Royal Commission, 1991). This review of the Mental Health Act further emphasizes the equality of mentally ill people and therefore may have influenced society's attitudes. As well, the British Columbia Royal Commission on Health Care and Costs (1991) has advocated the least restrictive setting and level of intervention consistent with quality care for mentally ill patients.

British Columbian nurses are not only exposed to the public campaigns but professional literature on mental health as well. In response to the review of the Mental Health Act, the R.N.A.B.C. produced a brief advocating that the same rules of informed consent apply to the mentally ill as apply to the population in general (1991). The R.N.A.B.C. position reaffirms the belief that each patient is entitled to information about the treatment they are to receive (1991) and endorses nurses as the first point of contact and primary health care provider (1990). The Canadian Nurses Association has also gone a long way in initiating changes in the care of mentally ill patients in Canada by the publication of the Mental Health Care Reform (1991).

American nurses will likewise be exposed to public awareness campaigns and influences from professional organizations. These influences may explain why there is an increase in the OMI scores for Benevolence and a decrease in the scores for Social Restrictiveness and Interpersonal Etiology from the Cohen and Struening 1962 study to the Wilcox 1987 study. As well, the factors that British Columbia nurses identified as influencing care of the mentally ill will likely be present and possibly exaggerated in American hospitals.

Deinstitutionalization of the mentally ill may explain the high scores seen in the Benevolence factor (factor B). It will be recalled that Benevolence has its roots in paternalism and humanism while acknowledging some fear of the mentally ill. Mentally ill patients now living in communities have often been prematurely moved into communities before adequate health care was in place. This is in contrast to the 1960's when many more patients lived in mental institutions away from the public eye. Therefore the plight of the

mentally ill is much more apparent on the streets of communities. This dramatic increase in the visibility of mentally ill people may have increased both paternalistic feelings and fear of the mentally ill in general hospital nurses both in the present study and the Wilcox (1987) study.

Another explanation for higher score on the Benevolence factor may be the socialistic culture present in British Columbia. The British Columbian health care system explicitly endorses the key principles of medicare: universality, comprehensiveness, accessibility, portability and public administration (Ramsey, 1994). Nurses, as one of the principle providers of health care, have their roots in humanism and view looking after others as a basic professional responsibility.

Mental Hygiene Ideology (factor C) showed lower scores compared with Cohen and Struening (1962), and to a lesser degree Wilcox (1987). This difference may represent a shift away from seeing mental illness as a medical problem like any other. This factor represents the belief that mentally ill patients can be treated and cured in the same way as other patients and that they will return to a normal life. The lower factor score in this study may be a result of a less optimistic attitude about the prognosis of mental illness than was prevalent in the 1960's. The 1960's were a time when it was felt that science and technology would soon have a fix for all problems. It may also be the result of a more discriminating attitude toward mental illness. In the sixties, there was hope that all psychotic patients would respond equally well to antipsychotics. It should also be noted that the low mean on the Interpersonal Etiology (factor E) is consistent with the view that most mental illness has a genetic component and therefore a poor prognosis.

Authoritarianism (factor A) does not appear to show a trend over time (see Table 10). The Wilcox (1987) study shows an increase in Authoritarianism while this study indicates a lower mean for Authoritarianism than either of the earlier studies. The factor Authoritarianism reflects a view of the mentally ill as an inferior class requiring locked institutional care and coercive handling. It is possible that differences in the attitudes of American nurses versus British Columbian nurses are the result of differences in Canadian versus American attitudes. It is interesting to note Cohen and Struening's (1962) comments on Authoritarianism. "The mentally ill may function as a negatively stereotyped outgroup in much the same way as do racial, religious, or political minority groups in the larger society" (p. 352).

Relationship of Variables to Attitudes Towards the Mentally Ill and Factors that Influence Care of the Mentally Ill

How nurses attitudes related to selected variables was determined by computation of the Pearson r coefficient. Data revealed that the most significant relationship was between advanced education beyond the diploma level and less socially restrictive attitudes towards the mentally ill. This finding is consistent with other studies that found education as significantly linked to more positive attitudes towards the mentally ill (Cohen & Struening, 1962, Scott & Phillip, 1985, Marsey, 1987, Wonsiak, 1994). Data also identified that additional education in the form of seminars, inservices and so forth had a significant influence on attitudes. This study's findings indicated that nurses who did not have additional education on the care of the mentally ill were somewhat more likely to ascribe to the belief that mental illness arose from interpersonal relationships and lack of love in childhood, and that mentally ill

patients should have their rights restricted. These attitudes conflict with the present philosophy of deinstitutionalization. The majority of nurses in this sample did not have either a baccalaureate degree or any further education on care of the mentally ill. However, they are expected to care for patients who are both mentally and physically ill.

The Wilcox (1987) study confirmed the significance of a link between more positive attitudes and education. Nurses in the Wilcox study attended a course on the etiology and care of mentally ill patients. As well, clinicians supported nurses on units with the care of mentally ill patients. On post test the nurses attitudes had significantly become more positive as measured by the OMI.

Fifty percent of the nurses who responded to the general questions identified lack of knowledge as a factor that interfered with their ability to care for mentally ill patients. The majority of nurses had not had any education on the care of mentally ill patients since leaving nursing school, an average of thirteen years ago. This lack of contemporary knowledge becomes somewhat alarming as deinstitutionalization moves more and more mentally ill patients into communities. Medical-surgical nurses in local general hospitals are increasingly required to care for the mentally ill residents of their communities.

Lack of time is a very real concern for nurses on busy task oriented medical-surgical units. Nurses commented that the tasks often took priority over talking with mentally ill clients. The lack of knowledge nurses identified as influencing care of the mentally ill may also prevent them from identifying the supportive psychological care mentally ill patients require. It also follows

that nurses may be attending to the physical needs of mentally ill patients while ignoring their psychological needs. Nurses who only attend to the physical needs of mentally ill patients are neglecting a vital component in these patients' health care needs.

It is somewhat surprising that significant relationships were not found for such variables as personal experience, town size or age. Nurses who had personal experience with individuals diagnosed with a mental illness were not significantly more positive or negative in their attitudes towards the mentally ill. The stereotype of people from small towns holding more conservative or restrictive attitudes did not hold true in this study; nurses working in towns with populations less than 10,000 were not significantly more positive or negative towards the mentally ill. Similarly, older nurses were not significantly more positive or negative towards the mentally ill.

OMI Tool

Additional findings indicated some concern by nurses over the wording and data produced through the use of the OMI tool. The OMI was developed and tested in the 1960's. The wording of some questions assumes that the respondent does not differentiate between various types of mental illness. This may be problematic as the respondent could, at times, be in conflict as to how to answer a question. They would answer one way in thinking about a patient with depression and another when considering a person with schizophrenia. The general increase in knowledge and understanding of the diversity of mental illness makes a non-discriminating tool quite cumbersome.

The relatively few respondents (8%) that commented on the OMI tool makes general interpretation impossible. However, this questioning of the

OMI indicates that a more specific and modern version of an OMI tool may be required if it is to be used in the future.

Summary of Findings

On the factors of Authoritarianism, Social Restrictiveness and Interpersonal Etiology, nurses in this study generally indicated a more positive attitude towards the mentally ill than was found in studies of American health workers in the past. Benevolence in this group of nurses was high, indicating a paternalistic and kindly view while acknowledging some fear of the mentally ill. Findings on the final factor, Mental Hygiene Ideology, are slightly lower than previous studies perhaps conveying a confusion as to whether to view mental illness as just another medical illness or as a different kind of illness, needing a different approach than the medical model.

Consistent with previous research, both advanced preparation and education about mental illness correlated significantly with a more positive attitude towards mental illness. Factors that affected a nurse's ability to care for mentally ill patients on medical-surgical units were: (a) a lack of time to devote to mentally ill patients, (b) a lack of knowledge about the care of mentally ill patients, (c) the physical layout of the unit, (d) a lack of support from other health care providers in caring for mentally ill patients, (e) the attitude that nurses held towards the mentally ill, and (f) fear of mentally ill patients.

CHAPTER SIX

CONCLUSIONS AND IMPLICATIONS

The purpose of this study was to describe attitudes of medical-surgical nurses towards the mentally ill. Variables that affect these attitudes and the factors that nurses identified as impacting the care of mentally ill patients were also explored. A summary of the conclusions drawn from this study and the implications for nursing practice, education, research will be presented in this chapter.

Conclusions

On the basis of this study the following conclusions about nurses working in medical-surgical units in British Columbia are made. The attitude toward mentally ill people is relatively positive. B. C. medical-surgical nurses hold a less authoritarian attitude than did nurses in previous American studies. They do not believe that mentally ill people are a threat to society and they recognize a biological basis to mental illness. However, some nurses do express a paternalistic attitude and acknowledge fear of the mentally ill in their attitudes. Lastly, nurses do not view mental illness in the same way as they would a medical illness.

Medical-Surgical Nurses identify a lack of time as impacting on their ability to care for mentally ill patients. Nurses also felt that they have a lack of knowledge about how to care for mentally ill patients. Other factors that nurses identify as negatively impacting on their ability to care for mentally ill patients are the physical layout of the unit, a lack of support from other

health care workers, the attitude they and others hold towards the mentally ill, and a feeling of fear of mentally ill patients.

Many variables contribute to the formation of attitudes, with education playing a significant role. Medical-Surgical Nurses with a diploma in nursing hold significantly more negative attitudes regarding the threat that patients pose to society than do nurses with more education. As well, nurses who have not had any inservice or other education on the care of the mentally ill seem more likely than those with such advanced education to hold a belief that mental illness arises from deprivation of love during childhood.

Implication for Nursing Practice

This research has further emphasized the importance of ongoing education in the formation of attitudes. Nurses' attitudes towards mentally ill patients affect their ability to assume the helping role and therefore influence caring for these patients. As the number of mentally ill patients that medical-surgical nurses are required to care for increases, so must their knowledge base about mental illness. How to assist nurses to stay abreast of the changes in care of the mentally ill is a vital question for hospital education departments to address. Are traditional inservice sessions effective in assisting nurses to care for the mentally ill? Do nurses need support on the ward to critically analyze the needs and care required by patients who are both physically and mentally ill? Nurses in this study were clear that they did not feel confident in caring for mentally ill patients. This leads to the conclusion that knowledge coupled with supported experience with mentally ill patients may be what is required to ensure that nurses gain the needed skills in caring of the mentally ill.

How does nursing service provide this supported experience? One approach could be the continued employment of mental health clinicians. These clinicians fulfill many vital roles. They provide support in the form of consultation on the care of mentally ill patients. Clinicians role model expert nursing care of mentally ill patients and assist nurses to identify their specific educational needs about the care of mentally ill patients. Mental health clinicians could also play a role in the research of how nurses could best meet their educational needs about the care of mentally ill patients.

The opinion that mentally ill patients do not require extra nursing time, just a different approach, was not substantiated in this study. This may hold true for the confident, experienced mental health nurse but nurses in this sample reported feeling afraid of mentally ill patients and lacking knowledge and skill necessary to care for these patients. They felt that mentally ill patients required much more time than their medical-surgical patients. The increase in time that mentally ill patients require could perhaps be partly alleviated through an increase in nurses' knowledge on how to care for the mentally ill. Infrequently used or new skills require longer to perform than routine care. Workload allocation on a medical-surgical unit is generally determined by the number of patients and nurses on a unit. Some consideration is given to the acuity of patients but workload formulae rarely acknowledge the extra time nurses report needing for the care of the physically and mentally ill patient. If nurses are going to improve the care they provide to these patients, there needs to be some recognition of the complex nursing care these patients require.

Implications for Nursing Education

Education seems to make a difference to the attitudes that nurses hold towards mentally ill patients. Nurses with baccalaureate degrees held less socially restrictive attitudes towards the mentally ill than nurses with a diploma education. Nurses with inservice education or advanced education seem to have an advantage in caring for the complex patient who is both medically and mentally ill. Educators and professional organizations have long recommended that the entry level education for nurses to practice be a baccalaureate degree. Education and support of nurses in caring for mentally ill patients appears to be greatly needed. The question is, what type of education and support do nurses need to adequately care for mentally ill patients on medical-surgical units?

Basic nursing curriculum have traditionally included four to eight weeks of psychiatric nursing experience. The objectives for this clinical experience vary widely. Is experience with mentally ill patients on an acute psychiatric unit going to prepare nurses to care for patients who are both mentally and physically ill? Nurses in this study did not feel they had sufficient knowledge to care for mentally ill patients and were reticent to intervene in the psychological care of these patients until a crisis occurred. They commented that they did not gain enough skills and knowledge from their nursing programs to be confident in caring for mentally ill patients.

It is not surprising that medical-surgical nurses have not furthered their education on the care of mentally ill patients since mental health is not their chosen area of focus. However, the fact remains that medical-surgical nurses will at times be required to care for mentally ill patients. Is it the

responsibility of hospitals to provide education on the care of mentally ill patients or is it a nurse's responsibility to seek it? And what type of education or training would best meet nurses' needs in caring for mentally ill patients? One research study found that inservice education coupled with on the unit support in implementing assessment and intervention techniques had a positive response (Wilcox, 1987) in improving the care of mentally ill patients.

How can nursing programs meet this identified learning need?

Perhaps nursing students need experience with mentally ill patients not only on psychiatric units but on medical-surgical units as well. To incorporate this experience into nursing programs would mean that educators would need to consciously help students seek experiences that required them to integrate mental health knowledge with their medical-surgical learning. Incorporating the care of patients who are both physically and mentally ill into one experience would mean a major shift in thinking for educators. Educators would need to develop a broad perspective and seek out complex medical-surgical patients who also have mental illnesses for student learning rather than eliminate them from assignments. Educators would also need to eliminate categories of teaching and instead develop learning opportunities that reflect the reality of the integration of mentally ill patients into communities.

Many educators, like medical-surgical nurses, are not confident in the care of mentally ill patients. To support students, educators could perhaps combine their resources by pairing medical-surgical instructors with mental health instructors to provide an integrated experience. Another way of providing students with the exposure to patients who are mentally and physically ill may be the incorporation of grand rounds for nurses. Medical-

surgical patients who are also mentally ill could be presented to a group of nurses so that they could gain a better understanding of the nursing problems and care these patients require.

Nursing programs across British Columbia are in the midst of major shifts in philosophy and curriculum design. The current redesign of curriculums provides an opportunity to incorporate changes in how care of mentally ill patients are taught in both acute psychiatric and medical units. This shift in focus would hopefully produce graduates who are better prepared to cope with the complexities of caring for patients who are both mentally and physically ill.

Implication for Nursing Research

Research on the attitudes that practicing nurses hold towards mentally ill patients is scarce. Perhaps one of the reasons is the lack of a current valid and reliable tool to measure these attitudes. The OMI was developed in the 1960's and now is somewhat outdated in the wording of some items. It also assumes that people have the same attitude toward one type of mental illness as they do to another. A more discriminating tool is needed to gain an in-depth understanding of nurses' attitudes towards people with various mental disorders.

This study superficially identified some of the factors that affect nurses' abilities to care for mentally ill patients. Effects of organizational structure, interpersonal relationships, and professional factors needs further exploration. Further research is also needed to fully understand the experience of medical-surgical nurses in caring for mentally ill patients. The perspective of mentally ill patients and patients' families on the medical-

surgical nursing care they receive would also add to our understanding of the needs of these patients. Observational and descriptive studies should be conducted to assess the relationship between nurses' attitudes and the actual care they provide to patients who are both physically and mentally ill. In addition, research is needed to identify the most effective strategies to assist nurses to cope with the demands of caring for these complex patients.

REFERENCES

- American Psychiatric Association: Task force on DSM-IV (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington D. C.: Author.
- Barnes, F. F., Mason, J. C. & Greer, C. (1983). Medical illness in chronic psychiatric outpatients. General Hospital Psychiatry 5, 191-195.
- Benner, P. (1984). From novice to expert: Excellence and power in clinical nursing practice. Menlo Park, CA: Addison-Wesley Publishing Company.
- Bickerstaff, L.K., Harris, S.C., Leggett, R.S. & Keong-Chye, C. (1988). Pain insensitivity in schizophrenic patients. Archives of Surgery, 123, 49-51.
- British Columbia Royal Commission on Health Care and Costs. (1991). Closer to home: Vol. 2. Report of the British Columbia Royal Commission on Health Care and Costs. Victoria, BC: Crown Publications Inc.
- Canadian Nurses Association. (1991). Mental health care reform: A priority for nurses. Ottawa, ON: Author.
- Cohen, J., & Struening, E. L. (1962). Opinions about mental illness in the personnel of two large mental hospitals. Journal of Abnormal and Social Psychology, 64, 349-360.
- Cohen, J., & Struening, E. L. (1963). Opinions about mental illness: Mental hospital occupational profiles and profile clusters. Psychological Reports, 12, 111-124.
- Cohen, J., & Struening, E. L. (1964). Opinions about mental illness: Hospital social atmosphere profiles and their relevance to effectiveness. Journal of Consulting Psychology, 28, 291-298.

- Cohen, J., & Struening, E. L. (1965). Opinions about mental illness: Hospital differences in attitude for eight occupation groups. Psychological Reports, 17, 25-26.
- Costin, F., & Kerr, W.D. (1962). The effects of an abnormal psychology course on students' attitudes toward mental illness. Journal of Educational Psychology, 53, 214-218.
- D'Ercole, A, Skodol, A.E., Struening, E., Curtis, J., & Millman, J. (1991). Diagnosis of physical illness in psychiatric patients using axis III and a standardized medical history. Hospital and Community Psychiatry, 42, 395-400.
- Fazio, R. H. (1986). How do attitudes guide behavior? In R. M. Sorrentino & E. T. Higgins (Eds.), Handbook of motivation and cognition: Foundations of social behavior (pp. 204-243). New York: The Guilford Press.
- Fishbein, M., & Ajzen, I. (1975). Belief, attitude, intention, and behavior: An introduction to theory and research. Don Mills, ON: Addison-Wesley Publishing Company.
- Holmberg, S. K & Kane, C.F. (1995). Severe psychiatric disorder and physical health risks. Clinical Nurse Specialist, 9, 287-292.
- Kahle, L. R. (1984). Attitudes and social adaptation. Oxford: Pergamon Press.
- Kahn, A. M. (1976). Relationship between nurses' opinions about mental illness and experience. Nursing Research, 25, 136-140.
- Krosnick, J. A., & Abelson, R. P. (1992). The case for measuring attitude strength in surveys. In J. M. Tanur (Ed.), Questions about questions: Inquiries into the cognitive bases of surveys. New York: Russell Sage.

- Lamb, R.H. (1991). Community treatment for the chronically mentally ill. Hospital and Community Psychiatry, 42(2), 117-125.
- Landeen, J., Byrne, C. & Brown, B. (1992) Journal keeping as an educational strategy in teaching psychiatric nursing. Journal of Advanced Nursing, 17, 347-355.
- Marsey, C. A. (1987). Personality and attitude change in psychiatric nursing as a function of nursing experience (Doctoral dissertation, University of California, 1987). Dissertation Abstracts International UMI #PUZ8820644.
- Meyer L.M. (1973) Comparison of attitudes toward mental patients of junior and senior nursing students and their university peers. Nursing Research, 22, 242-245.
- Olson, J. M., & Zanna, M. P. (1993). Attitudes and attitude change. Annual Review of Psychology, 44, 117-154.
- Polit, D. F. & Hungler, B. P. (1991). Nursing research principles and methods (4th ed.). Philadelphia: Lippincott.
- Rabkin, J. G. (1972). Opinions about mental illness: A review of the literature. Psychological Reports, 77, 153-171.
- Ramsey, P. (1994). Core services report. British Columbia: Canadian Cataloguing in Publication Data, New Directions Development Division.
- Registered Nurses Association of British Columbia. (1990). Position statement: New directions for health care. Vancouver, B.C.: Registered Nurses Association of British Columbia.

- Registered Nurses Association of British Columbia. (1991). Response to the issues and options paper mental health act review: A brief to the ministry of health. Vancouver, B.C.: Registered Nurses Association of British Columbia.
- Reznikoff, M. (1963). Attitude of psychiatric nurses and aides toward psychiatric treatment and hospitals. Mental Hygiene, 47, 360-364.
- Roskin, G., Carsen, M. L., Rabiner, C. J., & Lenon, P. A. (1986). Attitudes toward patients. Journal of Psychiatric Education, 10(1), 40-49.
- Roskin, G., Carsen, M. L., Rabiner, C. J., & Marell, S. K. (1988). Attitudes toward patients among different mental health professional groups. Comprehensive Psychiatry, 29(2), 188-194.
- Scott, D. J. & Phillip, A. E. (1985). Attitudes of psychiatric nurses to treatment and patients. British Journal of Medical Psychology, 58, 169-173.
- Statistics Canada Canadian Centre for Health Information. (1992). Health reports: Mental health statistics 1989-90 (Catalogue 82-003S3, Supplement No. 3, 4, No. 1). Ottawa: Minister of Industry, Science and Technology.
- Swain H. L. (1973). Nursing students' attitudes toward mental illness. Nursing Research, 22(1), 59-65.
- Tabachnick B. G. & Fidell, B. G. (1989). Using multivariate statistics 2nd ed.: New York: Harper and Row.
- Weller, L., & Grunes, S. (1988). Does contact with the mentally ill affect nurses' attitudes to mental illness? British Journal of Medical Psychology, 61, 277-284.

- Wilcox, A. H. (1987). Personality characteristics and attitudes toward mental illness in general hospital nurses: Feasibility of change (Doctoral dissertation, University of Miami, 1987). Dissertation Abstracts International, 3965, 8813706.
- Wilson, T. D., Dunn, D. S., Draft, D. & Lisle, D. J. (1989). Introspection, attitude change, and attitude-behavior consistency: The disruptive effects of explaining why we feel the way we do. Journal of Advanced Experimental Social Psychology, 22, 278-343.
- Wonsiak, P.A. (1994). Mental illness, offenders, and offender rehabilitation: A comparison of the attitudes of nurses working in different clinical practice settings. (Master thesis, University of Saskatchewan, 1994).
- Wright, F. H., & Klein, R. A. (1966). Attitudes of hospital personnel and the community regarding mental illness. Journal of Counseling Psychology, 13, 106-107.

APPENDIX A

OPINIONS ABOUT MENTAL ILLNESS

The statements that follow are opinions or ideas about mental illness and mental patients. By mental illness, we mean the kinds of illness which bring patients to mental hospitals. There are many differences of opinion about this subject. In other words, many people agree with each of the following statements while many people disagree with each of these statements. We would like to know what *you* think about these statements. Each of them is followed by six choices:

strongly____	agree____	not sure____	not sure____	disagree____	strongly____
agree		but probably	but probably		disagree
		agree	disagree		

Please check (✓) in the space provided that choice which comes closest to saying how you feel about each statement. You can be sure that many people, including doctors, will agree with your choice. There are no right or wrong answers: we are interested only in *your opinion*. It is very important that you answer *every* item. Please do **NOT** sign your name.

1. Nervous breakdowns usually result when people work too hard.

strongly____	agree____	not sure____	not sure____	disagree____	strongly____
agree		but probably	but probably		disagree
		agree	disagree		

2. Mental illness is an illness like any other.
3. Most patients in mental hospitals are not dangerous.
4. Although patients discharged from mental hospitals may seem all right they should not be allowed to marry.
5. If parents loved their children more, there would be less mental illness.
6. It is easy to recognize someone who once had a serious mental illness.
7. People who are mentally ill let their emotions control them: normal people think things out.
8. People who were once patients in mental hospitals are no more dangerous than the average citizen.
9. When a person has a problem or a worry, it is best not to think about it, but keep busy with more pleasant things.
10. Although they usually aren't aware of it, many people become mentally ill to avoid the difficult problems of everyday life.
11. There is something about mental patients that makes it easy to tell them from normal people.

12. Even though patients in mental hospitals behave in funny ways, it is wrong to laugh about them.
13. Most mental patients are willing to work.
14. The small children of patients in mental hospitals should not be allowed to visit them.
15. People who are successful in their work seldom become mentally ill.
16. People would not become mentally ill if they avoided bad thoughts.
17. Patients in mental hospitals are in many ways like children.
18. More tax money should be spent in the care and treatment of people with severe mental illness.
19. A heart patient has just one thing wrong with him, while a mentally ill person is completely different from other patients.
20. Mental patients come from homes where the parents took little interest in their children.
21. People with mental illness should never be treated in the same hospital as people with physical illness.
22. Anyone who tries hard to better himself deserves the respect of others.
23. If our hospitals had enough well trained doctors, nurses, and aides, many of the patients would get well enough to live outside the hospital.
24. A woman would be foolish to marry a man who has had a severe mental illness, even though he seems fully recovered.
25. If the children of mentally ill parents were raised by normal parents, they would probably not become mentally ill.
26. People who have been patients in a mental hospital will never be their old selves again.
27. Many mental patients are capable of skilled labor, even though in some ways they are very disturbed mentally.
28. Our mental hospitals seem more like prisons than like places where mentally ill people can be cared for.
29. Anyone who is in a hospital for a mental illness should not be allowed to vote.
30. The mental illness of many people is caused by the separation or divorce of their parents during childhood.
31. The best way to handle patients in mental hospitals is to keep them behind locked doors.
32. To become a patient in a mental hospital is to become a failure in life.
33. The patients of mental hospitals should be allowed more privacy.
34. If a patient in a mental hospital attacks someone, he should be punished so he doesn't do it again.
35. If the children of normal parents were raised by mentally ill parents, they would probably become mentally ill.
36. Every mental hospital should be surrounded by a high fence and guards.
37. The law should allow a woman to divorce her husband as soon as he has been confined in a mental hospital with a severe mental illness.

38. People (both veterans and non-veterans) who are unable to work because of mental illness should receive money for living expenses.
39. Mental illness is usually caused by some disease on the nervous system.
40. Regardless of how you look at it, patients with severe mental illness are no longer really human.
41. Most women who were once patients in a mental hospital could be trusted as baby sitters.
42. Most patients in mental hospitals don't care how they look.
43. College professors are more likely to become mentally ill than are business men.
44. Many people who have never been patients in a mental hospital are more mentally ill than many hospitalized mental patients.
45. Although some mental patients seem all right, it is dangerous to forget for a moment that they are mentally ill.
46. Sometimes mental illness is punishment for bad deeds.
47. Our mental hospitals should be organized in a way that makes the patient feel as much as possible like he is living at home.
48. One of the main causes of mental illness is a lack of moral strength or will power.
49. There is little that can be done for patients in a mental hospital except to see that they are comfortable and well fed.
50. Many mental patients would remain in the hospital until they were well even if the doors were unlocked.
51. All patients in mental hospitals should be prevented from having children by a painless operation.

PLEASE CHECK BACK AND MAKE SURE THAT YOU HAVE NOT LEFT
OUT ANY STATEMENTS OR PAGES OF STATEMENTS.

Note: The summary of questions is provided for information only. The material is copyrighted and may not be reproduced.

APPENDIX D

GENERAL QUESTIONNAIRE

The questions in this form ask for general information, your education, experience with mentally ill patients and any factors you think affect your ability to care for mentally ill patients on a medical or surgical unit. Remember that all your answers are completely anonymous and confidential so please answer as honestly as possible.

Complete the form by filling in the blanks or circling the appropriate response. Thank-You.

1. Gender:
Male ____
Female ____

3. Marital Status:
Single ____
Married ____
Divorced ____
Other(please specify) _____

3. Race:
Caucasian ____
Oriental ____
Black ____
Other(please specify) _____

4. Your age is: _____

5. What is your highest level of nursing education:
Diploma ____
Baccalaureate ____
Masters ____

6. What clinical area do you presently work in:
Medical ____
Surgical ____
Other(please specify) _____

7. What is the population of the city/town you work in?
Less than 10,000 ____
10,000-50,000 ____
more than 50,000 ____

8. How long have you been practicing nursing?
_____ years _____ months
9. Is your present job:
Part-time _____
Full-time _____
10. Did you have a psychiatric clinical experience in your education?
Yes _____
No _____
11. Have you ever worked in a mental health or psychiatric setting?
Yes _____
No _____
If yes, for how long? _____
12. Have you attended any inservices or educational training in how to care for mentally ill patients?
Yes _____
No _____
13. Have you had any personal experience with individuals diagnosed with a mental illness?
(self, friend, close relative)
Yes _____
No _____
14. Please identify any factors you feel affect your ability to care for mentally ill patients in the clinical area you now work in.

15. Please add any other comments you wish regarding the care of mentally ill patients in a medical or surgical setting.
