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The effect of occupational therapy curriculum on students' attitudes toward mental illness

Deborah Ann Ferris
Ithaca College

THE EFFECT OF OCCUPATIONAL THERAPY CURRICULUM ON STUDENTS' ATTITUDES TOWARD MENTAL ILLNESS

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Deborah Ann Ferris

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Thesis Advisor: Marilyn Kane MA, OTR/L

Committee Members: Mindy Cozzolino OTR/L, MS, CRC, BCN, Craig Nicholls Ph.D

Abstract

The number of occupational therapists working in the mental health field has declined over the past several decades for a variety of reasons, including the attitudes toward mental illness held by new graduates. The structure and content of an occupational therapy curriculum is designed to foster positive attitudes toward individuals with mental illness through the acquisition of knowledge and clinical experience that provides students contact with individuals with disabilities. This study compares the effect of two different educational curricula and Level II psychosocial fieldwork on occupational therapy students' attitudes toward mental illness and interest in working in the mental health field. Participants in the study included 115 graduate occupational therapy students. A demographic survey and the Opinions About Mental Illness Scale (OMI) were the measurement tools used in this study. The results of the study show that graduate occupational therapy students display positive attitudes toward mental illness. Curriculum type did not impact attitudes or interest, though the completion of a Level II fieldwork showed a significant effect on students' interest in working in the mental health field. The implications for occupational therapy are that more opportunities need to be developed within the curriculum to increase students' experience with mental illness, including the establishment of Level I and Level II fieldwork sites in the mental health field.

Ithaca College

School of Health Sciences and Human Performance

Ithaca, NY

CERTIFICATE OF APPROVAL

This is to certify that the Thesis of

Deborah Ann Ferris

Submitted in partial fulfillment of the requirements for the degree of
Master of Science in the Department of Occupational Therapy, School of Health Sciences and Human Performance at Ithaca College has been approved.

Thesis Advisor: _____

Candidate: _____

Chair, Graduate Program in Occupational Therapy: _____

Dean of Graduate Studies: _____

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Dedication

This thesis is dedicated to my mom and dad, whose love, support, and encouragement have made this all possible.

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Chapter 1: Introduction

Mental illness affects millions of individuals and their families in the United States and across the world. According to the National Institute of Mental Health (NIMH), approximately 22.1 percent of Americans are diagnosed with a mental illness (2001). These numbers translate to 44.3 million people when applied to the 1998 Census population estimate (NIMH, 2001). In a 1990 worldwide study of individuals 18 and older, unipolar depression, bipolar affective disorder, schizophrenia, and obsessive-compulsive disorder were included in the top ten leading causes of disability (Murray, & Lopez, 1996). The number of individuals living with mental illness and requiring professional support has become a major health care issue. Health professionals, including physicians, occupational therapists, and nurses, play a crucial part in the rehabilitation and community integration process for individuals with mental illness.

Background

Occupational therapy is one of the many health professions that provides services for individuals with mental illness. The profession of occupational therapy was founded in the early 20th century with a treatment focus on engaging individuals with mental illness in activities and routines to promote adaptation (Schwartz, 1998). Throughout the century, occupational therapists have continued to work in the mental health field, although not as predominantly as in the early part of the century. Following the deinstitutionalization of patients in mental hospitals in the late 1960s and the introduction of individuals with mental illness into the community, the value of psychosocial occupational therapy lessened and drug therapies became the treatment of choice (Schwartz, 1998). Even now, over 30 years later, occupational therapy practice in the

mental health field continues to struggle as it decreases in size and recognition; other areas of practice, especially physical rehabilitation and pediatrics, have become the larger foci of the profession (Mental Health Education Task Force (MHETF), 1995). The AOTA Member Compensation Survey (2000) reported that 5.2% of the survey respondents worked in the mental health field, while 29.2% worked in schools or early intervention programs. A number of reasons have been given for the decline in the number of occupational therapists working in the mental health field. These include problems defining the role of occupational therapy in mental health, difficulty receiving reimbursement for services with this population, and inadequate training during professional education (Wittman, Swinehart, Cahill & Michel, 1989).

In addition to occupational therapists, a variety of other health care professionals provide services within the mental health arena, including physicians, psychologists, psychiatrists, recreational therapists, social workers, and nurses. Attitudes of health professionals toward individuals with disabilities, especially mental disorders, play an important part in the delivery of services. Attitudes exhibited by health professionals shape their relationships with their clients (Altman, 1981), as well as impact the client's response to treatment (Lyons & Hayes, 1993). As a result, the attitudes of health professionals, including occupational therapists, are of concern due to the tremendous impact they can have on individuals receiving services. This is especially true with individuals suffering from mental illness because of the cultural stigma associated with psychiatric conditions (Brown & Bradley, 2002).

Due to the significance that attitudes toward mental illness can have on the quality of the services they receive, it is essential to foster positive attitudes toward individuals

with mental illness in health care professionals. This is true of occupational therapists, who play an important role on the interdisciplinary team that works with individuals with mental illness. The attitudes that occupational therapists have toward individuals with disabilities have a significant role in forming the therapeutic relationship with the client (Ebenhardt & Mayberry, 1995). One way to influence the development of positive attitudes is during students' professional education (Estes et al., 1991). According to the American Occupational Therapy Association (AOTA), one objective of occupational therapy curricula is to influence students' attitudes (AOTA, 1983). Occupational therapy curricula provide students with a holistic view of the person and various treatment methods, including psychosocial practice. Although occupational therapists integrate psychosocial concepts into treatment for all clients, for the purpose of this study, psychosocial occupational therapy will refer to the interventions used specifically with mental health conditions. The structure and content of occupational therapy curricula is designed to foster positive attitudes through the acquisition of knowledge and clinical experience that provides students contact with individuals with disabilities. For the remainder of this study, curriculum will refer to the academic coursework portion of occupational therapy education. When discussing fieldwork, it will be discussed separately and not included in the term curriculum.

Currently, there are two general types of structure given to 5-year baccalaureate/master's degree occupational therapy programs. This structure does not refer to the teaching methods that are used by educators, but rather to the placement of psychosocial content within the curriculum. One type, referred to as embedded psychosocial curriculum, includes exposure to psychosocial theories and treatment within

the coursework of other classes. Typically, these curricula are designed on a developmental basis, meaning the coursework is designed based on the life span of the individual rather than diagnosis. Coursework is divided into developmental stages, such as pediatrics, adolescents, adults, and geriatrics.

The second structure used to design occupational therapy programs is an overt psychosocial curriculum. This structure consists of coursework divided specifically by area of practice, for example: neurological, psychosocial, and physical rehabilitation. Overt psychosocial occupational therapy curricula also tend to provide more opportunity for a psychosocial fieldwork, whereas an embedded psychosocial curriculum focuses on completing fieldworks covering the life span. The differences in the two types of curricula, although appearing subtle, may have varying impacts on fostering positive attitudes toward individuals with disabilities, more specifically mental disorders. In addition, the curricula may have different impacts on developing students' interests in a career in the mental health field.

Problem Statement

The number of occupational therapists practicing in the mental health field has decreased over the past several decades. The reason for this decline has been attributed to a number reasons including difficulty defining the role of occupational therapy in mental health, a lack of reimbursement for services, and inadequate training during professional education (Wittman et al., 1989). The Mental Health Education Task Force (1995) reported that additional causes of the decline might be due to perceived salary discrepancies with other areas of practice, as well as students' fear of working with individuals with mental illness. Another possibility is that occupational therapy students'

attitudes toward mental illness have contributed to a lack of new graduates entering the field. Although there are several studies researching the effects of occupational therapy curricula on students' attitudes toward individuals with disabilities, few of these studies focus specifically on mental illness and the effects on students' interest in this area of practice. In addition, there is no research comparing the effects of different types of curricula on these variables.

Purpose

The purpose of this study is to compare the effect of two different educational curricula on occupational therapy students' attitudes toward mental illness and perspectives of the mental health field. The two types of occupational therapy curricula that will be compared are that of an embedded psychosocial focus and that of an overt psychosocial focus. The study will compare attitudes toward mental illness held by occupational therapy graduate students enrolled in each type of curriculum. Furthermore, the study will compare the students' level of interest in pursuing an occupational therapy career in the mental health field. For the purpose of this study, graduate students will refer to those students enrolled in their 5th year of a 5-year entry-level master's degree program in occupational therapy.

Significance

Occupational therapy, as a profession, has its roots in the mental health field. However, there have been recent trends in occupational therapy away from this realm of practice. Occupational therapy students' attitudes toward both mental illness and the psychosocial domain of practice may be one factor contributing to the shift in the field. The results of this study will help educational instructors understand the trends in

occupational therapy students' attitudes toward mental illness and psychosocial practice and the impact they may be having on the mental health field. Occupational therapy students may need more exposure to mental illness or to psychosocial practice if the study finds attitudes that are not consistent to being a holistic practitioner. In addition, professors may want to include activities that promote introspective thinking to help students understand their attitudes and the effect it can have on their interaction with individuals with mental illness. The results of the study may also provide guidance for program development based on the comparison of results between the two types of curricula. Occupational therapy programs that are planning for or are moving from a bachelor's degree to an entry level master's program may use the results to organize course structure and content in order to foster positive student attitudes.

Hypothesis

Compared to graduate students in an occupational therapy curriculum with an embedded psychosocial focus, graduate students completing an occupational therapy curriculum with an overt psychosocial focus will:

a) Demonstrate significantly more positive attitudes toward mental illness

b) Express significantly more interest in choosing an occupational therapy job in the mental health field

Additional analyses will look at the effects of Level II psychosocial fieldwork on attitudes and students' interest in the mental health field. Other factors such as age and personal experience will also be investigated.

Definition of Terms

DSM-IV-TR is the most current version of the Diagnostic and Statistical Manual of Mental Disorder. It is a reference for health care professionals used to describe criteria for diagnosing mental disorders, as well as provide information on epidemiology and differential diagnosis.

Mental illness/mental disorder, according to the *DSM-IV-TR*, is a clinically significant behavioral pattern or psychological syndrome that is associated with present distress or disability, or an increased risk for pain, disability, loss of freedom, or death.

Embedded psychosocial occupational therapy curricula is designed to incorporate psychosocial concepts into general coursework, typically divided based on human development. Level II fieldwork requirements are based on covering the life span, rather than specific treatment areas.

Overt psychosocial occupational therapy curricula have coursework designed to focus on general treatment areas. It would typically include a course specific to psychosocial practice. A student enrolled in this type of program would be more likely to complete a psychosocial Level II fieldwork.

Chapter 2: Literature Review

Mental illness is a broad term used to describe a number of conditions. In the United States, physicians classify mental illness based on the text revision of the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV-TR*), published in 2000 by the American Psychological Association (APA). The *DSM-IV-TR* provides criteria to assist in diagnosis, in addition to describing manifestations of the mental disorders, epidemiology, and differential diagnosis (Kaplan & Sadock, 1996). According to the *DSM-IV-TR*, mental illness, referred to as a mental disorder, is the presentation of significant behavioral patterns or psychological syndromes that is associated with distress or disability. (APA, 2000). A mental disorder may also present with an increased risk for pain, disability, loss of freedom, or death. A diagnosis would not be made if the syndrome or behavioral pattern were associated with a predictable or culturally accepted response to an event, such as the death of a loved one. Furthermore, a conflict with society or deviant behavior, whether religious, political, etc., would not be classified as a mental disorder unless it is a symptom of a dysfunction in the individual (Kaplan & Sadock, 1996).

Professional Attitudes

The delivery of health care services is impacted by the attitudes held by health professionals. These attitudes shape the relationships formed between health professionals and their clients (Altman, 1981). As a result, negative attitudes held by health professionals toward disabilities are a concern because they may affect the quality of care that individuals with disabilities receive. Occupational therapists' attitudes toward disabilities are a significant factor in developing the therapeutic relationship

(Eberhardt & Mayberry, 1995). In a study done by Eberhardt and Mayberry (1995), it was found that entry-level occupational therapists generally exhibited positive attitudes toward individuals with disabilities. The authors attribute these attitudes toward individuals with disabilities to contact with these individuals both in and out of the professional setting, as well as professional education (Eberhardt & Mayberry, 1995). This study looked at disabilities in general; attitudes toward specific disabilities, such as mental illness, may not be as favorable within the profession.

Health care providers that work in the mental health field need to be aware of their attitudes toward mental illness, as well as the attitudes of the general community. The risk that health services may be compromised due to negative attitudes is more likely among individuals with mental illness, due to its cultural stigma (Brown & Bradley, 2002; MHETF, 1995). In addition, the client's response to treatment is influenced by his or her health providers' attitudes (Lyons & Hayes, 1993). Since occupational therapists' interventions with individuals with mental illness aim to maximize independence in daily routines, attitudes held by occupational therapists could have a considerable effect on an individual's return to function (Eberhardt & Mayberry, 1995). As a result, developing favorable attitudes toward mental illness in the occupational therapy profession is a major concern to ensure this population receives the highest quality of care. Professional education is just one of the significant influencing factors that can help foster positive attitudes toward disabilities, including mental illness.

Student Attitudes

Student Attitudes Toward Disabilities

Professional education has the potential to change student attitudes toward individuals with disabilities. A stated objective of occupational therapy curricula is to influence student attitudes by providing course content related to values and attitudes (AOTA, 1983). According to Lee, Paterson, and Chan (1994), learning includes changes in ways of thinking, feeling and acting as a result of experiences provided by the student's curriculum. Occupational therapy students' experiences include exposure to accurate information about a variety of disabilities and contact with individuals with disabilities through level I and level II fieldworks (Lee et al., 1994).

Estes, Deyer, Hansen and Russell (1991) completed a study examining the effects of occupational therapy curricula on student attitudes toward persons with disabilities. Participants included freshman and senior occupational therapy students, as well as freshman and senior medical technology students. Attitudes toward persons with disabilities were measured using the Attitudes Toward Disabled Persons Scale (ATDP). Their results showed that fourth year occupational therapy students expressed more positive attitudes than first year occupational therapy students, as well as both first and fourth year medical technology students (Estes et al., 1991). The researchers concluded that the change in occupational therapy students' attitudes was due to course content addressing disabilities and contact with individuals with disabilities throughout the curriculum. The medical technology students did not receive as much coursework regarding persons with disabilities and had only little contact with individuals with disabilities (Estes et al., 1991). The study did not control for the effects of maturation on

students' attitudes toward mental illness. In addition, the study did not examine the separate effects of coursework and clinical contact with individuals with disabilities on influencing attitudes.

Lee, Paterson, and Chan (1994) also looked at the effect of occupational therapy curricula on students' attitudes toward individuals with disabilities. During the end of the first semester of the academic year, students completing their second, third, and fourth years of occupational therapy curricula were asked to complete two sets of the ATDP-Form A, one to recall their attitudes prior to beginning their professional education (retrospective pretest) and one to assess their current feelings (posttest). The results of the study showed more positive student attitudes after attending the occupational therapy program. However, it should be noted that due to the cross-sectional nature of the study, changes in attitudes were based on comparing current scores to retrospective scores, which may not be accurate in assessing previous attitudes. Therefore, although the study found significant changes between attitudes on the retrospective pretest and the posttest, the limitations of the study need to be considered when determining the significance of the results. In addition, the study did not find a correlation between student attitudes and year in the program (second, third, or fourth year students); instead, a leveling of attitudes was seen in the students after an initial change, a process known as maturation, that occurred immediately following the beginning of occupational therapy coursework in the second year of study (Lee et al., 1994).

Student Attitudes Toward Mental Illness

Comparison with attitudes toward other disabilities. Student attitudes toward individuals with disabilities have been researched in more detail to address particular

populations such as individuals with mental illness. Lyons and Hayes (1993) conducted a study to investigate attitudes in occupational therapy and business students. Using the Disability Social Distance Scale (DSDS) and a demographic questionnaire, the researchers surveyed freshman business students and occupational therapy students in their freshman through senior year of study. Freshman occupational therapy students indicated a desire for less social distance from individuals with mental illness than the freshman business students; however, there was no difference between the desired social distance from individuals with mental illness between freshman and senior occupational therapy students (Lyons & Hayes, 1993). Lyons and Hayes also ranked the disabilities in the surveyed based on preferences on the DSDS. Not surprisingly, mental illness was one of the least preferred disabilities, along with mental retardation, alcoholism and possession of a criminal record.

More recently, Penny, Kasar and Sinay (2001) assessed occupational therapy students' attitudes toward a variety of disabilities in a study done on attitudes toward mental illness. Their study found students' attitudes toward individuals with mental illness were significantly less favorable than toward individuals with other disabilities both prior to and following psychosocial coursework and level I fieldwork. There were no significant differences found in the students participating in the study. The findings of this study (Penny et al., 2001) and Lyons and Hayes' (1993) study are of concern for occupational therapists and educators as the number of practitioners in the mental health field continues to decline. These studies also raise questions about the effectiveness of occupational therapy education in developing positive attitudes toward individuals with mental illness.

Impact of Curriculum on Attitudes. There have been numerous studies conducted to assess student attitudes toward mental illness and the factors that may contribute to attitude development (Gilbert & Strong, 2000; Graessle, 1997; Malla & Shaw, 1987; McLaughlin, 1997; Penny et al., 2001). There have been mixed findings related to the impact of coursework and clinical contact on creating more positive attitudes in students. A study was completed to assess the influence of an instructional and experiential training program centered around mental illness on nursing students' attitudes and perceptions of individuals with mental illness (Malla & Shaw, 1987). The students' attitudes and perceptions were measured using the Opinions about Mental Illness Scale (OMI) and a number of short case descriptions with questions. Malla and Shaw found that although nursing students expressed positive attitudes toward individuals with mental illness, the training program had little impact on fostering more positive attitudes. Instead, the researchers found that the training program only influenced the students' abilities to identify the presence and severity of mental illness. Similarly, in a study conducted by Graessle (1997) on the attitudes of occupational therapy students about mental illness, there was no significant difference in attitudes between students with and without structured mental health experience. Graessle classified structured mental health experience as volunteer service or work in a mental health setting for a total of more than 10 hours. This description applies to both Level I and Level II fieldwork, showing that fieldwork did not significantly impact the students' attitudes toward mental illness.

Some researchers have found a positive influence of curricula and clinical contact on students' attitudes toward mental illness (Gilbert & Strong, 2000; McLaughlin, 1997; Penny et al., 2001). In a study conducted with second year nursing students, McLaughlin

(1997) found that classroom theory influenced students' attitudes toward both mental illness characteristics and treatment toward the mentally ill. After completing coursework, students expressed more favorable attitudes toward patient characteristics, in addition to significantly more positive attitudes toward the treatment of individuals with mental illness. The study did not show a significant impact in improving attitudes from clinical experience with mental illness. However, attitudes remained positive following fieldwork, demonstrating that coursework was not contradicted by contact with individuals with mental illness (McLaughlin, 1997).

Gilbert and Strong (2000) found that professional education influenced occupational therapy students' attitudes, but through fieldwork experience rather than classroom instruction. The students completed a two-hour per week fieldwork in a community setting for individuals with mental illness for the duration of twelve weeks. The students' attitudes were assessed using the Community Attitudes towards the Mentally Ill Questionnaire (CAMI) both before and after the fieldwork. The CAMI is a 40-question attitude scale that measures attitudes toward mental illness based on four scales: authoritarianism, benevolence, social restrictiveness, and community mental health ideology. The results showed significantly more positive attitudes in the occupational therapy students' attitudes following a fieldwork experience in a mental health setting. Gilbert and Strong also found that occupational therapy students' attitudes prior to the fieldwork were more positive than those measured in the community in other studies (2000).

Penny, Kasar and Sinay (2001) conducted a study of occupational therapy students' attitudes to measure the influence of coursework and level I Fieldwork.

Differences in attitudes toward individuals with either mental illness or physical disabilities were assessed using the ATDP-A, while content of attitudes toward mental illness was measured using the OMI. The OMI is similar to the CAMI in that it classifies attitudes toward mental illness into scales (Authoritarianism, Benevolence, Mental Hygiene Ideology, Social Restrictiveness, and Interpersonal Etiology) to identify not just the overall attitudes, but also the content of the attitudes. The researchers reported that attitudes toward persons with mental illness became more favorable following psychosocial coursework; however, Level I fieldwork did not produce the same effect. The results of the ATDP-A showed no significant change in attitudes following Level I fieldwork, but the contents of the attitudes, measured by the OMI, were found to become more negative. This study also looked at student preferences toward mental health practice and found that following both coursework and the Level I fieldwork, a majority of students (75.6%) said they would be willing to consider working in the mental health field, as opposed to only 22.2% that stated an interest in mental health was present prior to their experiences (Penny et al., 2001).

Occupational therapy students' attitudes toward mental illness may be one of the factors contributing to the decline in the number of occupational therapists practicing in the mental health field. It has been suggested that less favorable attitudes expressed by occupational therapy students about individuals with mental illness as opposed to other disabilities has resulted in fewer new graduates entering the field (Lyons & Hayes, 1993). As occupational therapy educators consider the decline in interest in mental health, it is essential to look at the curriculum and the influence it has on attitudes. There is conflicting evidence from research studies on the impact of occupational therapy

curricula on developing more positive attitudes in students. Further research needs to validate or refute the effectiveness of occupational therapy curricula on fostering more favorable attitudes toward mental illness. From this research, curricula can be redesigned and structured in a way that takes students' attitudes toward disabilities, especially mental illness, into consideration (Penny et al., 2001).

Occupational Therapy Curricula

Overview of Occupational Therapy Programs

Individuals interested in pursuing a degree in occupational therapy currently have a number of options open to them. In the United States, there are over 140 colleges and universities that offer occupational therapy programs accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) (AOTA, 2001). The programs fall into several categories: baccalaureate programs, combined baccalaureate/master's programs, and professional entry-level master's program. In addition to these options, practitioners in the field can return to school to receive post-professional degrees and doctorates. Many baccalaureate programs have closed admission and are redesigning their programs to meet the new master's degree requirement that will go into effect in January 1, 2007 (ACOTE, 2001).

There are currently 34 combined baccalaureate/master's degree programs offered in the United States that are accredited by ACOTE. Some of the programs organize the curriculum content based on human development and the life span. Psychosocial occupational therapy principles are integrated into the appropriate courses. For the purposes of this study, this type of curriculum will be referred to as embedded psychosocial occupational therapy curriculum. The other structure used to design

combined baccalaureate/master's degree programs is to separate course work based on treatment principles and interventions. Geriatric and pediatric occupational therapy often still have their own coursework due to their level of specialty. Psychosocial occupational therapy principles and interventions would be taught in a class specific to this area of practice. These programs will be referred to as overt psychosocial occupational therapy curricula.

Embedded Psychosocial Occupational Therapy Curriculum

Occupational therapy curricula with an embedded psychosocial approach incorporate psychosocial evaluations and treatment into the life span curricula. Psychosocial interventions are taught with the developmental group they correspond with, such as adolescent, adult, and geriatric populations. The occupational therapy program offered at College Misericordia located in Dallas, Pennsylvania is organized under this principle (College Misericordia, 2001). The five-year baccalaureate/master's program coursework is divided based on life span development. The curriculum is structured with courses called OT Intervention Series I through III. The course description of OT Intervention Series II is as follows:

> Theory, frames of reference, assessment processes, and intervention planning and techniques are explored as they apply to individuals whose occupational performance is affected by various developmental, physical and psychosocial conditions. This second of three courses in the intervention series presents the occupational therapy process for individuals from adolescence through middle adult. This course includes clinical based, Level I fieldwork experience (College Misericordia, 2001).

In a similar design, Mercy College's baccalaureate/master's program introduces major occupational therapy principles in a sequential series of courses named Childhood and Occupational Therapy Practice, Adolescence and Occupational Therapy Practice,

Adulthood and Occupational Therapy Practice, and Geriatrics and Occupational Therapy Practice (Mercy College, 2001). Adulthood and Occupational Therapy Practice addresses the psychosocial components of practice in addition to addressing theoretical approaches to other conditions such as motor, cognitive, and perceptual dysfunctions. In addition to these core courses, assessment and treatment principles used with adult clients are more specifically addressed in two other courses called Occupational Therapy Assessment IV-Adults and Occupational Therapy Treatment IV-Adults (Mercy College, 2001). An embedded psychosocial occupational therapy curriculum is an organized way to arrange course content, based on human development and life span principles.

Overt Psychosocial Occupational Therapy Curriculum

Occupational therapy curricula with an overt psychosocial focus separates coursework related to areas of practice. Similar to an embedded psychosocial occupational therapy curriculum, these programs often have separate pediatric and geriatric courses to emphasize the special knowledge that relates to these particular populations. The main difference lies in the course content typically covered in an adult interventions class. Psychosocial rehabilitation and physical disability rehabilitation are the two main practice areas that are broken down in this type of curriculum. For example, the combined baccalaureate/master's occupational therapy program at the University of Scranton, in Scranton, Pennsylvania, offers four Occupational Therapy Practice courses covering pediatrics, psychosocial rehabilitation, physical rehabilitation, and geriatrics. The course description for Occupational Therapy Practice II: Psychosocial Rehabilitation is as follows:

> An overview of theoretical frames of reference, evaluation, and treatment intervention strategies used to enhance the function of individuals with

> psychosocial dysfunction. Methods of observation, assessment, and treatment approaches are introduced and practiced in lab simulations and field trips to area facilities. Two hours lecture, two hours lab/week, and a minimum total of ten hours of service learning (University of Scranton, 2001).

In addition, the curriculum includes a level I fieldwork in psychosocial rehabilitation for two weeks the summer following the third year of study. A 12-week level II psychosocial rehabilitation fieldwork is required for all students in the program following either the fourth or fifth year of study (University of Scranton, 2001).

This is one example of the curriculum design included in an overt psychosocial occupational therapy program. Other schools follow similar course designs, such as the University of Central Arkansas, which offers two specific psychosocial courses: Evaluation and Treatment in Mental Health I and II (University of Central Arkansas, 2001). Students enrolled in the occupational therapy program at Worcester State College in Worcester, Massachusetts, take four courses that address psychosocial occupational therapy. Therapeutic Approaches, Therapeutic Approaches Lab I/Level I Fieldwork, and Occupational Performance & Context I and II address performance in life roles, function/dysfunction continuum, theoretical approaches, clinical reasoning, and intervention strategies, in addition to providing clinical fieldwork, all related to psychosocial occupational therapy (Worcester State College, 2001). An overt psychosocial occupational therapy curriculum is one of the popular education designs used to organize course contents.

Summary

The impact of professional education on occupational therapy students' attitudes toward individuals with mental illness has been looked at by a number of researchers (Gilbert & Strong, 2000; Graessle, 1997; Malla & Shaw, 1987; McLaughlin, 1997; Penny

et al., 2001). A number of these studies have shown that a curriculum has the potential to influence students' attitudes in a favorable manner (Gilbert & Strong, 2000; McLaughlin, 1997; Penny et al., 2001). However, the difference in structure of these curricula in relation to attitudes has not been researched. A comparison of the impact on attitudes of an embedded psychosocial occupational therapy curriculum versus an overt psychosocial occupational therapy curriculum, for instance, has not been previously researched. This comparison will be the focus of the present study.

Chapter 3: Methodology

This study investigated the attitudes of occupational therapy students toward mental illness and the impact of curricula design on these attitudes. Two types of occupational therapy curricula design, one with an overt psychosocial focus and one with an embedded psychosocial focus, were compared in their ability to positively influence student attitudes toward mental illness. In addition, the results of this study were used to assess the hypothesis that graduate students in an occupational therapy curriculum with an overt psychosocial focus would be more likely to choose a career in the mental health field than graduate students in an occupational therapy curriculum with an embedded psychosocial focus.

A survey research design was used to gather data for this study. Participants in the study were asked to complete two surveys: a demographic information survey and an attitude scale. The surveys were presented to the participants by the researcher to avoid the problems associated with mail surveys, such as poor return rates.

Participants

The population for this study was occupational therapy students enrolled in a five-year baccalaureate/master's degree program the United States. Prior to selecting a sample, all the 5-year occupational therapy programs in the United States were reviewed to check that program trends were reflective of the two types of curricula being investigated in this study. Programs were researched through the AOTA's list of occupational therapy schools on the Internet (AOTA, 2001). The five-year programs were divided based upon the curriculum design that was used to structure the program, either overt or embedded psychosocial focus. The programs were selected for either the

overt or embedded category after a close examination of the curriculum including course titles and course descriptions. A convenience sample, based on the location of the researcher, was used to select the sample, limiting the possible occupational therapy programs to those in the northeastern region of the United States. Two occupational therapy programs from both categories of curricula were chosen for the sample in this study. Graduate students were selected to participate in the study since they have completed the largest portion of the occupational therapy curriculum, compared to the other classes (freshmen, sophomore, junior, and senior). As a result, the graduate students would be the most representative sample to measure the types of attitudes that occupational therapy students have when they finish their professional education.

Operationalization of Concepts

Attitudes Toward Mental Illness

Attitudes toward mental illness will be measured using the Opinions About Mental Illness Scale (OMI) (see Appendix C). Attitudes will be assessed based on scoring in the five areas of the tool including Authoritarianism, Benevolence, Mental Hygiene Ideology, Social Restrictiveness, and Interpersonal Etiology. This scale is explained in more detail below.

Participants' Demographic Characteristics

Demographics will be gathered through using the Participant Demographic Survey (see Appendix C). Information collected includes age, gender, whether the participant has completed a Level II psychosocial fieldwork in a mental health setting, and personal experience with mental illness.

Interest in Choosing a Job in the Mental Health Field

Students' interest in choosing a career in the mental health field will be based on their responses to two questions on the Participant Demographic Survey. These questions address their likelihood of applying for a job in the mental health field following graduation and their interest in pursuing a career in this area of practice.

Classification of Occupational Therapy Curriculum

The occupational therapy programs being sampled in this study will be categorized as either having an overt or embedded psychosocial focus. Overt psychosocial curricula organize the coursework based on area of disabilities and have a class focusing specifically on psychosocial occupational therapy. Embedded psychosocial curricula integrate psychosocial concepts and interventions within other broad courses.

Graduate Students

For the purpose of this study, graduate students will refer to students enrolled in five-year baccalaureate/master's degree programs in occupational therapy. The students will be receiving entry-level master's degree in occupational therapy, as opposed to advanced master's degrees or post-professional degrees.

Measurement Instruments

Participant Demographic Survey

The Participant Demographic Survey was developed by the researcher to gather information on several characteristics of the sample. The tool has six questions that the participants answered regarding age, gender, whether a Level II psychosocial fieldwork had been completed, personal experience with mental illness, and level of interest in a job

or career in the mental health field. Age was measured in years, while gender was selected from either male or female. Participants that answered yes to completing a Level II psychosocial fieldwork were asked to respond to an additional open-ended question to briefly describe the patient populations at the site and the intervention techniques used. This information was gathered to ensure that those individuals reporting that they had completed a psychosocial fieldwork that met the criteria set by the researcher. Personal experience was assessed by asking the participant to mark whether they had experience with a family member, friend, or community member with mental illness. The participant could also fill in a blank for any other experience he or she felt was worth acknowledging. There was also a response that could be marked for no contact with individuals with mental illness. Two Likert-scaled questions were designed to elicit a person's interest in working in the mental health field. One question asks about the participant's likelihood in applying for a job in the mental health field following the completion of his or her degree, while the other question asks about their interest in pursuing a career in the mental health field.

Opinions About Mental Illness Scale (OMI)

Design. The OMI was developed by Cohen and Struening in the early 1960s. It is a 51 question Likert scale survey that assesses attitudes toward mental illness, as well as the etiology and treatment of mental illness. The authors developed the scale as a result of the growing belief that patients in hospitals for the mentally ill were sensitive to the attitudes of the hospital personnel and that successful community reentry was dependent on the attitudes of the general public (Cohen & Struening, 1962). The OMI asks respondents to rate their level of agreement with each of the statements using a six option

rating scale: strongly agree, agree, not sure but probably agree, not sure but probably disagree, disagree, and strongly disagree. In order to make the tool more appropriate and up to date for this study, the language was changed to reflect more acceptable wording. For example, "mental patient" was rephrased as either "individual with mental illness" or "individual hospitalized for mental illness" depending on the context of the statement. Since the language was changed only to update the tool and not to change content, the psychometric properties of the tool should be unaffected.

The items on the OMI are organized into five Factors to measure the content of attitudes toward mental illness (Struening & Cohen, 1963). High scores in the Factors indicate beliefs consistent with that ideology.

- Factor A – Authoritarianism represents the beliefs that individuals with mental illness are inferior and need strict and forceful management (11 items).
- Factor B – Benevolence embodies a paternalistic view that is based on religious or humanistic views rather than a scientific viewpoint; individuals with mental illness are seen as childlike, however their illness can still cause a level of fear (14 items).
- Factor C – Mental Hygiene Ideology represents the idea that mental illness is the same as any other type of illness (9 items).
- Factor D – Social Restrictiveness indicates the belief that individuals with mental illness are a threat to society and need to be restricted in order to protect the community (10 items).

- Factor E – Interpersonal Etiology symbolizes the thought that mental illness is caused by a person's experiences, especially those occurring in childhood, such as the relationship with his or her parents (7 items).

There is no total score for the OMI that can be used to measure attitudes. Instead, the OMI is scored based on totaling scores in each of the five Factors. A strong score in a particular subscale indicates a belief consistent with that Factor's ideology. When used to determine overall attitudes, low scores on Factor A – Authoritarianism, Factor D – Social Restrictiveness, and Factor E – Interpersonal Etiology, and high scores on Factor B – Benevolence and Factor C – Mental Hygiene Ideology represent favorable attitudes toward mental illness (Penny, Kasar & Sinay, 2001).

Cohen and Struening (1962) developed the OMI by first gathering 200 opinion items regarding various aspects of mental illness and then had them reviewed by experienced researchers. Following this review, 55 questions were chosen for the original tool to which the authors added 15 additional items that were taken from previously existing attitude toward mental illness scales. The 70-item tool was administered to the personnel of two hospitals with sample sizes of 541 and 653 participants. From the data, the researchers identified the five Factors using factor analysis and omitted 19 questions that poorly correlated with their Factor, resulting in the final 51-item attitude measurement tool.

Reliability. Struening and Cohen found internal consistency coefficients for the five Factors following a study conducted with a total sample of 1200 employees from three different hospitals (Struening & Cohen, 1963). The values reported for internal consistency are as follows: .77 to .80 for Factor A, .70 to .72 for Factor B, .29 to .39 for

Factor C, .71 to .76 for Factor D, and .65 to .66 Factor E. No further data has been gathered on the reliability of the OMI. The poor internal consistency for Factor C – Mental Hygiene Ideology will be taken into account during data analysis.

Data Gathering

This research study was submitted to the Ithaca College Review Board for Human Subjects Research prior to beginning data collection. Approval for the study was received in December of 2001 (see Appendix B). The process of data gathering took place in mid-December of 2001 by initiating contact with potential occupational therapy programs that fit the criteria of either an overt or embedded psychosocial focus. The contact process continued into January, following the winter break period. Data gathering using the Participant Demographic Survey and the OMI took place late January into early February of 2002. The researcher administered the surveys to the groups of students participating in the study. The participants were informed that the study was gathering data on students' attitudes and opinions about mental illness. Each participant received a packet including a recruitment statement discussing the study (see Appendix D), an informed consent form to be signed (see Appendix E), the Participant Demographic Survey, and the OMI. The participants' responses were anonymous and their participation in the study was kept confidential.

Data Analysis and Interpretation

Data analysis on the survey data took place during late February through early March 2002. The software program used for data analysis was the Statistical Package for the Social Sciences, Version 11.0 (SPSS, 2001). The first step to data analysis was scoring both the Participant Demographic Survey and the OMI. The answers to the

questions on the OMI were assigned values of one through six for the choices in the agree-disagree continuum. Items on the OMI that were inversely related to their Factor were then reverse coded so that mean scores for each Factor could be calculated. The next step in data analysis was to evaluate the internal consistency of the five OMI Factors. Based on the output from these analyses, questions from four of the Factors were removed to improve the internal consistency of the scales. Internal consistency analysis was rerun following the deletion of items to find the final Cronbach's alpha coefficients for the five OMI Factors.

The scores for the five OMI Factors were determined by calculating the mean score for the questions grouped in each factor. Independent samples *t*-tests were used to test the formal hypotheses involving curriculum type, as well as to explore the influence of Level II psychosocial fieldwork. Furthermore, a regression analysis was used to determine the specific effects of age, curriculum type, personal experience and completion of a Level II fieldwork experience on the two interest questions, as well as the five OMI Factors.

Delimitations

This study focused only on five-year baccalaureate/master's degree programs in occupational therapy. The results of this study cannot be generalized to four-year baccalaureate programs or to two-year master's programs. In addition, this study focused on attitudes toward mental illness and not general disabilities. The tools being used to gather data asked questions only relevant to mental illness and did not explore opinions about other groups of individuals with disabilities.

Assumptions

This study was being conducted under several assumptions. The first was that attitudes can be influenced by external factors. More specifically, attitudes toward mental illness can be altered as a result of outside influences, such as education and life experiences. Another assumption of this study was that the students participating in the study would answer the survey questions honestly and without regard to social desirability, and that the OMI is an accurate measurement tool for attitudes toward mental illness.

Limitations

There were several limitations to this study, including the selected sample and the use of the OMI. The sample was chosen based on convenience and did not use a random-sampling procedure. In addition, only three occupational therapy programs were included in the study from the original plan of four. The OMI was developed in the early 1960s and contains outdated language and some outdated content. Although the language was altered to reflect more current terms, some of the questions refer to ideas that are not necessarily as predominant in the medical community as they were four decades ago. In addition, Factor C of the OMI (Mental Hygiene Ideology) has both poor validity and internal consistency. This study was also limited in its ability to account for external factors influencing attitudes besides occupational therapy education. The Participant Demographic Survey helped address part of this limitation by asking about personal experience with mental illness beyond that provided by professional occupational therapy curricula.

Chapter 4: Results

Participants

A total of 115 graduate students from three different occupational therapy programs participated in the study. Two participating programs used the embedded psychosocial design for curricula ($n^1 = 50$, $n^2 = 25$) for a total of 75 students. Students from the third program ($n = 40$) were enrolled in a curriculum which was structured with an overt psychosocial design. The sample population was 10.4% male ($n = 12$) and 89.6% female ($n = 103$). This gender split is similar to the data gathered by AOTA on its membership, which is representative of the occupational therapists working in the United States (female = 93.8%, male = 6.2%) (AOTA, 2000). The ages ranged from 21 to 43 ($n = 114$), with the majority of the participants falling between ages 22 and 23 (68.7%). 21% of the participants were over the age of 25 and may be classified as nontraditional students. There were no significant differences between the participants in the two types of curricula.

Opinions About Mental Illness Scale

The first step in data analysis focused on the OMI. Questions on the OMI were numerically coded on a scale of 1 to 6 based on the response, with strongly disagree scored as a 1 and strongly agree scored as a 6. The questions corresponding with each Factor (A - Authoritarianism, B - Benevolence, C - Mental Hygiene Ideology, D - Social Restrictiveness and E - Interpersonal Etiology) were then analyzed to determine the degree of internal consistency. The results yielded Cronbach's alpha (α) coefficients ranging from .17 to .71. After reviewing the results from these analyses, items that poorly correlated with the other questions in the Factor were thrown out to improve the

internal consistency of the scale. A total of 8 questions were omitted from the final scoring of the OMI before continuing with the data analysis. The internal consistency figures for the OMI Factors, both prior to and following the deletion of questions are presented in Table 1 (Appendix A). As shown in the table, Factor C – Mental Hygiene Ideology is the weakest scale of the OMI, which is consistent with the initial psychometrics conducted by the original authors (Cohen & Struening, 1963). However, the final internal consistency value for Factor C in this study was .51, which is significantly higher than the internal consistency (.39) found by Cohen and Struening (1963). As a result, Factor C is considered valid for use in the analysis of attitudes in this study. The internal consistency of Factor D was significantly improved after revising the scales by deleting one item that did not correlate with the other questions.

Testing the Hypothesis

The first hypothesis tested in this study was that students in an overt psychosocial occupational therapy curriculum would have more positive attitudes than students in an embedded psychosocial curriculum. This hypothesis was not supported by the data. Table 2 (Appendix A) shows the mean scores and standard deviations for the scores of students in each type of curriculum for each Factor of the OMI. Independent samples *t*-tests (two-tailed) were used to compare students in both types of curricula with the scores on each Factor. Table 3 (Appendix A) shows the results of the *t*-tests comparing students in both types of curricula and their scores on each Factor of the OMI. As shown in the table, there were no significant differences on any of the five Factors of the OMI between students enrolled in an overt psychosocial occupational therapy curriculum and students in an embedded psychosocial curriculum.

This study also investigated the impact of curriculum type on interest in working as an occupational therapist in the mental health field. Two questions from the Participant Demographic Survey addressed this issue: one asking about the likelihood of applying for a job in the mental health field following graduation and the other asking about interest in pursuing a career in the mental health field. Scores were numerically coded 1 to 5 based on the responses to the Likert-scaled questions (1= very unlikely or extremely uninterested and 5=very likely or very interested). The two interest questions were significantly correlated with one another ($r = 0.87, p < .01$). Table 4 (Appendix A) shows descriptive statistics for the participants' scores for these two questions. Independent samples *t*-tests (two-tailed) were used to examine the relationship between curriculum type and interest in working in the mental health field. There was no significant impact of type of curriculum on either the likelihood of applying for a job ($t(113) = 1.16$, *ns*) or interest in pursuing a career in the mental health field ($t(113) = 1.63$, *ns*).

Additional Analyses

Additional data analysis investigated the effect of completing a Level II psychosocial fieldwork on both attitudes and interest in working in the mental health field. Although formal hypotheses were not stated, it was expected that those students that had completed the Level II psychosocial fieldwork would demonstrate more positive attitudes toward mental illness and show more interest in working the mental health field. Out of the total 115 participants, 38 students (33%) reported having completed a Level II psychosocial fieldwork. None of the occupational therapy programs involved in the study required that a student complete a Level II fieldwork in a mental health setting. Of

the 38 students that completed this type of fieldwork, 27 were enrolled in an occupational therapy curriculum with an embedded focus (36.0%, $n = 75$), and 11 were enrolled in a curriculum with an overt psychosocial component (27.5%, $n = 40$). Table 5 (Appendix A) shows the means and standard deviations for the Factors on the OMI in relation to the completion of a Level II psychosocial fieldwork. Table 6 (Appendix A) shows the results of independent samples *t*-tests (two-tailed) relating the completion of a Level II psychosocial fieldwork to scores on the OMI. No significant differences were noted on any of the five OMI Factors with respect to the type of curricula.

Further analysis of the data was used to address the impact of completing a Level II psychosocial fieldwork on students' interest in working in the mental health field. As explained previously, the two questions on the Participant Demographic Survey (applying for a job following graduation, interest in career in the mental health field) were used to measure interest. Table 7 (Appendix A) shows the means and standard deviations for participants' responses to the interest questions based on their fieldwork experience. Independent-samples *t*-tests (two-tailed) were used to compare the mean scores between students who had completed a Level II psychosocial fieldwork and those who had not. Significant differences were found between participants that had completed a Level II psychosocial fieldwork and those who had not completed one on both the job application item ($t(113) = -6.64, p < .0001$) and the interest in a career item ($t(113) = -6.56, p < .0001$).

Several other findings were found following additional data analysis. Age was found to have a weak significant correlation with the mean scores of Factor C ($r = .21$, $p < .05$), but not with the other four OMI Factors or with the interest questions from the

Participant Demographic Survey (see Table 8 in Appendix A). An individual's level of personal experience with individuals with mental illness, which was rated on a scale of 0 to 4, weakly correlated with his or her interest in pursuing a career in the mental health field ($r = .20, p < .05$), and was approaching significance in its relationship to the likelihood of applying for a job in the mental health field following graduation ($r = .17$, $p = .07$). In addition, regression analysis showed that there was a significant relationship between personal experience and the likelihood of applying for a job after controlling for age, curriculum type, and the completion of a Level II psychosocial fieldwork ($t(109) = 1.99, p < .05$).

Personal experience was also analyzed to determine the individual effects of the types of experience on attitudes, which included having a family member or friend with mental illness or contact with community members with mental illness. Participants could also respond that they had no contact with individuals with mental illness or fill in a blank for other worthwhile experiences. The most significant result of independent samples *t*-tests found that individuals with a family member with mental illness indicated stronger agreement with Factor B of the OMI ($t(113) = 2.16, p < .05$). Also, contact with community members had a positive relationship with Factor D of the OMI ($t(113) = 2.27$, $p < .05$).

In an analysis of outcome measures, Pearson correlations were run to find the relationships between the two items measuring interest (applying for a job, interest in a career in the mental health field) and the five OMI Factors. These analyses are a correlation of outcome measure. Results showed that both the likelihood of applying for a job ($r = -.27, p < .01$) and the level of interest in pursuing a career in the mental health

field ($r = -.19, p < .05$) were inversely related to scores on Factor B – Benevolence. There was no significant relationship between the interest questions and the other four OMI Factors (see Table 9 in Appendix A).

Chapter 5: Discussion

Discussion of Findings

Overall, the occupational therapy students that participated in this study demonstrated positive attitudes toward mental illness, as evidenced by their scores on the OMI. The participants agreed most strongly with Factor C – Mental Hygiene Ideology of the OMI, which embodies the belief that mental illness is similar to other diseases. Factor B is also representative of favorable attitudes, however the participants' attitudes did not include the ideals held by this Factor, which are paternalistic toward individuals with mental illness. In addition, the participants' low scores on Factors A, D, and E indicate favorable attitudes toward mental illness. These results show that the decline in new occupational therapy graduates entering the mental health is not necessarily a result of negative attitudes toward mental illness.

Professional education in both nursing and occupational therapy has been shown to positively influence attitudes toward mental illness (Gilbert & Strong, 2000; McLaughlin, 1997; Penny, Kasar & Sinay, 2001). The participants in this study were all in their fifth and final year of an occupational therapy curriculum. The near completion of the curriculum may have been an influencing factor in developing the positive attitudes toward mental illness that were reported in this study. Additional longitudinal research is needed to examine the overall effects of completing occupational therapy curricula on the development of attitudes.

The findings of this study show that there were no significant differences in attitudes toward mental illness between graduate students enrolled in an occupational therapy program with an overt psychosocial focus compared to those in an occupational

therapy program with an embedded psychosocial focus (see Table 2 and Table 3). The similarity of attitudes displayed by all the participants implies that occupational therapy programs designed with either type of curriculum, overt or embedded, are both equally effective in developing and/or maintaining positive attitudes toward mental illness. These results reject the first hypothesis. The implications of these findings for occupational therapy lie in the development of curriculum design for new programs and those that are restructuring. As previously discussed, the Accreditation Council for Occupational Therapy Education (ACOTE), in conjunction with an entry-level study committee formed by AOTA, has created a postbaccalaureate entry-level requirement for occupational therapists that is set to begin January 1, 2007 (ACOTE, 2001). As a result, many 4-year baccalaureate programs will be adding a fifth year of study and restructuring curricula to meet the new guidelines, while new programs will be more likely to develop 5-year programs. The results of this study suggest that both an overt psychosocial focus and an embedded psychosocial focus curriculum are acceptable educational designs for occupational therapy programs when examining their impact on student attitudes toward mental illness.

In addition, the data show that there is no significant difference between students in either type of curricula regarding their level of interest in working in the mental health field, which rejects the second hypothesis. These data support the conclusion that either curriculum design, overt psychosocial focus or embedded psychosocial focus, is suitable for occupational therapy programs. There was a significant inverse relationship between interest in working in the mental health field and Factor B of the OMI, but no further notable relationships were found between interest and the four other OMI Factors. Factor

B represents a very paternalistic attitude that individuals with mental illness need to be cared for rather than being responsible for their own independence. As a participant's agreement with Factor B increased, their interest in working in the mental health field decreased. One reason may be the desired relationship between occupational therapists and their clients. Ideally in occupational therapy, the client directs his or her treatment in a collaborative effort with the therapist. If a student strongly agrees with Factor B of the OMI, he or she does not feel that an individual with mental illness has the capability of participating in this type of therapeutic relationship. As a result, the student may not be interested in working with individuals with mental illness because he or she may feel occupational therapy treatment would not be an effective intervention without the collaborative component of therapy.

Similar results were noted with participants that reported having a family member with mental illness. These students scored higher on Factor B of the OMI, expressing the paternalistic viewpoint of mental illness. A possible reason for this finding is the role the student with a family member with mental illness may play in that person's life. The students may take on a care-giving type of role with their family members, which will influence their attitudes toward mental illness.

Participants in agreement with the ideals of Factor B, in addition to disagreement with the negative scales, are considered to have positive attitudes. However, this did not indicate a greater interest in working in the mental health field than other participants. The findings suggest that favorable attitudes toward mental illness do not necessarily equate to new graduates choosing to enter that field of practice. It can be concluded that

although occupational therapy curricula promotes the development of positive attitudes toward mental illness, it must be designed to foster interest in this area of practice.

One way occupational therapy curricula provides additional exposure to an area of practice such as mental health is through both Level I and Level II fieldworks. This study focused on the impact of Level II fieldworks completed in a mental health setting on both attitudes and interest in this area of practice. There was no significant difference in attitudes between students with and without the Level II psychosocial fieldwork experience. Consequently, the expectation that students who had completed a Level II psychosocial fieldwork would have more positive attitudes than those who did not, was not upheld. Other studies have found that clinical experience has a limited impact on improving attitudes toward mental illness if the students' attitudes were positive prior to the experience (McLaughlin, 1997). It can be inferred from this study that the participants that completed a Level II psychosocial fieldwork had favorable attitudes toward mental illness prior to the clinical experience due to the similarity of attitudes among all of the participants, including those that did not participate in this type of fieldwork.

The impact of Level II psychosocial fieldwork was seen in the participants' interest in working in the mental health field. Students who completed a 12-week Level II fieldwork in a mental health setting demonstrated significantly more positive scores on the two interest questions (see Table 7), suggesting that participation in this type of fieldwork can foster interest in the mental health area of practice. Since a Level II fieldwork in the mental health field was not a specific requirement for the participants in this study, some of the students may have selected his option based on an interest in the

field that was present prior to the experience. The data collected is not sufficient to address this issue. However, due to the large number of criteria that influence the selection of a fieldwork site, including location and housing options, these findings are significant enough to indicate an association between the completion of a Level II psychosocial fieldwork and interest in working in the mental health field. Similar results were found in a study conducted by Penny, Kasar, and Sinay (2001), who reported that following a Level I fieldwork experience, 75.6% of the participants were willing to consider working in the mental health field, as compared to only 22.2% prior to the experience (2001). The results from this study, taken together with those from Penny, Kasar, and Sinay, demonstrate that both Level I and Level II fieldwork experience can have a significant impact on developing an occupational therapy student's interest in working in the mental health field.

An individual's personal experience with mental illness was also shown to have an impact on their interest in the mental health field, though it varied in its influence on the development of positive attitudes. As stated previously, students with family members diagnosed with mental illness scored higher on Factor B, signifying a positive, but paternalistic attitude toward mental illness. In contrast, students indicating contact with community members with mental illness displayed stronger feelings of agreement with Factor D, which is a negative Factor. These findings indicate that different types of personal experience can both positively and negatively impact on students' attitudes toward mental illness.

The impact of personal experience on interest in the mental health field was similar to that of Level II psychosocial fieldwork. When controlling for Level II

psychosocial fieldwork, personal experience remained a significant factor in the level of interest an individual showed in working in the mental health field. However, it was found that the completion of a Level II psychosocial fieldwork had a much stronger relationship with the level of interest in the mental health field than personal experience. One possible reason for this may be that a person's personal experience with a number of individuals with mental illness may not be perceived as intense an experience as therapeutic intervention with this population. Numerous encounters in the community may provide an individual with only casual or superficial contact with mental illness, while working with individuals with mental illness provides opportunities for more in depth and intense relationships. There is not enough evidence from the data gathered in this study to support this concept, but it is a potential area for exploration in future studies. The data does suggest that experience with mental illness, both on a personal level and during a clinical experience, can help develop a student's interest in the mental health field, but not necessarily positively influence attitudes toward mental illness.

The implication of this study for occupational therapy programs is that providing opportunities for students to work and interact with individuals with mental illness is necessary to encourage new graduates to enter this area of practice. Although occupational therapy students without experience with mental illness still develop favorable attitudes, they will be less likely to explore the mental health field as an area of future practice. This finding is troubling due to the decrease in the number of psychosocial fieldwork sites available for occupational therapy students (Kautzmann, 1995). Many schools have restructured fieldwork requirements in order to deal with the difficulty in placing a large number of students at the limited number of psychosocial

sites. Occupational therapy educators and practitioners in the mental health field need to work together to develop more opportunities for students to explore this area of practice. Expanding students' experience with mental illness may have a significant positive impact on the decline in the numbers of new occupational therapy graduates entering the mental health field.

Another significant finding of the study is the effect of age on attitudes. A significant positive relationship was found between age and scores on Factor C of the OMI, meaning that as an individual increased in age, he or she was more likely to agree with this ideology. Since agreement with Factor C represents positive attitudes, the findings imply that older students have more favorable attitudes toward mental illness. The Mental Health Education Task Force (1995) reported that fieldwork supervisors in the mental health field found that nontraditional occupational therapy students excelled in mental health settings due to life experiences and a greater level of maturity than younger students. Although older students may have more life experience influencing their attitudes, the older participants in this study did not have significantly different amounts of personal experience with mental illness than the younger participants. In addition, age did not have a significant effect on students' interest in working in the mental health field. This finding supports the suggestion that an individual's experience with mental illness plays the most significant factor in developing interest in the mental health field.

The results of this study suggest that experience with mental illness, both personal and clinical, appears to have the most significant influence on developing interest in working as an occupational therapist in the mental health field. Limited experience with mental illness may be one of the factors contributing to the decline in the number of new

graduates entering the mental health field. Providing opportunities for students to work with individuals with mental illness prior to receiving their degrees may help to renew interest in the mental health field, which has been a traditional setting for occupational therapists since the profession's inception.

Fieldwork coordinators in occupational therapy programs need to actively seek new contacts within the mental health field so that students have more mental health options available to them. This proposal supports the recommendation of the Mental Health Education Task Force (1995) to include more clinical experience with mental health within occupational therapy curricula. By providing a greater variety of mental health settings in a number of locations, it will increase the likelihood of a student selecting a psychosocial fieldwork. In addition, addressing the possibility of completing a Level II fieldwork in a mental health setting should begin during psychosocial coursework in order to foster interest while the students are engaged in the topic. Developing Level I fieldwork opportunities in mental health settings is another way to increase occupational therapy students' experience with mental illness. Enjoyable experiences with mental illness during a Level I fieldwork may result in students seeking a Level II fieldwork in a mental health setting. Consequently, there is more potential for students to develop interest in working as an occupational therapist in the mental health field.

Limitations

It is essential to discuss the limitations of the study in order to accurately evaluate the results. The most significant limitation was the use of the OMI to measure attitudes. The OMI was developed in the 1960s and addresses several concepts related to mental

illness that are outdated in the medical field. The OMI was selected for use in this study because it is one of the few attitude assessments that relates specifically to mental illness. The poor internal consistency of Factor C found by the original authors was potentially a limitation. However, after omitting several questions, the internal consistency of Factor C was increased to within acceptable limits for research purposes. The selection process for participants resulted in a sample that was not randomized. Furthermore, the study examined only several external factors that may have influenced attitudes or interest in the mental health field. For example, although age and personal experience with mental illness were addressed, other factors, such as portrayal of mental illness in the media, were not researched. Another potential limitation is that only one occupational therapy program used an overt curriculum and only two used embedded curricula; therefore the strength of the teaching and attitudes of faculty could not be controlled.

Delimitations

The results of this study can be generalized to 5-year entry-level master's occupational therapy programs that fit into the criteria of an overt or embedded psychosocial focus. The findings do not necessarily apply to 2-year master's programs or 4-year baccalaureate programs. The three occupational therapy programs participating in this study were located in the northeast region of the United States. Attitudes and interests may vary based on geographical location, as well as the areas in which the students originally resided.

Chapter 6: Conclusion

The purpose of this study was to address the effect of two types of occupational therapy curricula and Level II psychosocial fieldwork experience on attitudes toward mental illness and interest in working in the mental health field. It was found that occupational therapy students in their final year of study held positive attitudes toward mental illness. These results imply that both overt and embedded psychosocial occupational therapy curricula encourage the development of positive attitudes. Furthermore, the suggestion that the decline in the number of new occupational therapy graduates entering the mental health field is due to negative attitudes is not supported by this research.

In addition, personal and clinical experience with mental illness was determined to foster interest in mental health. The impact of personal experience on interest in the mental health field was not as powerful as Level II psychosocial fieldwork. The implication of this finding is the need to provide more occupational therapy students with experience with mental illness. This experience should include the development of Level I and Level II fieldwork sites in mental health settings, as well as encouraging students to explore this area of practice throughout the curriculum.

There is a need for more research regarding attitudes toward mental illness and practice preference of occupational therapy students. There are a variety of measurement tools designed to examine attitudes toward mental illness, but they are outdated and address concepts no longer applicable to current attitudes and trends. The development and use of new attitude measures to look at attitudes toward mental illness will increase the validity of future research studies addressing this area. Longitudinal studies

examining attitudes toward mental illness of occupational therapy students would be beneficial to look at the change in attitudes as a result of curricula versus maturation.

Additional research on attitudes should be conducted to determine the content of attitudes that is most consistent with interest in the mental health field. For example, although both Factor B and Factor C of the OMI represent positive attitudes, they stand for very different viewpoints. This study found that although the occupational therapy students displayed positive attitudes toward mental illness, the content of the attitudes impacted their interest level in working in the mental health field. Learning about the underlying content of attitudes in regards to mental illness, as well as other disabilities, is important in understanding why there is not always a connection between positive attitudes and interest in relation to practice preference.

Another area of future research that is briefly addressed in this study is the effect of age on attitudes and interest in the mental health field. Factors such as prior work experience and personal life experiences should be investigated to determine the cause for varying attitudes in different age groups. Occupational therapy students' age may also influence practice preference. Trends in practice preferences of nontraditional students are an important topic to explore, especially for occupational therapy programs that have higher enrollments of nontraditional students.

The impact of personal experience on an individual's interest in the mental health field should also be investigated. This research should address both the intensity of the personal experience, as well as the duration of the experience. Although this study found that both personal experience and the completion of level II psychosocial fieldwork increased interest, it would be interesting to learn whether the students with the most

personal experience actively sought out this type of fieldwork experience. Additional research is needed to determine factors that influence students to select a Level II fieldwork in a mental health setting, such as career interest. In general, there is a need to expand the research regarding occupational therapy students' attitudes toward mental illness and the influence of Level I and Level II psychosocial fieldwork experiences.

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Appendix A

Table 1

Descriptive Statistics of Opinions About Mental Illness Scale (OMI)

OMI Factor	Number of Items		α^a-coefficient	
	Original OMI	Revised OMI	Original OMI	Revised OMI
A - Authoritarianism	11	9	.44	.60
B – Benevolence	14	13	.54	.60
C – Mental Hygiene Ideology	9	5	.37	.51
D – Social Restrictiveness	10	9	.17	.64
E – Interpersonal Etiology	7	7	.71	.71

[a]α represents Cronbach's coefficient of internal consistency.

Table 2

Descriptive Statistics of OMI by Curriculum

OMI Factor	*M*		*SD*	
	Overt[a]	Embedded[b]	Overt[a]	Embedded[b]
A - Authoritarianism	2.16	2.14	0.55	0.38
B – Benevolence	2.22	2.11	0.47	0.35
C – Mental Hygiene Ideology	4.05	3.87	0.64	0.70
D – Social Restrictiveness	2.51	2.51	0.57	0.51
E – Interpersonal Etiology	2.02	2.01	0.50	0.55

Note. Scoring for the OMI is based on the following numerical scale: 1 = strongly agree, 2 = agree, 3 = not sure but probably agree, 4 = not sure but probably disagree, 5 = agree, 6 = strongly agree.
[a](n = 40). [b](n = 75).

Table 3

Independent samples t-test of OMI Factors for Curriculum

OMI Factor	$t(113)$	p[a]
A - Authoritarianism	-0.26	.80
B – Benevolence	-1.25	.21
C – Mental Hygiene Ideology	-1.31	.19
D – Social Restrictiveness	-0.02	.99
E – Interpersonal Etiology	-0.09	.94

[a]Two-tailed.

Table 4

Descriptive Statistics of Interest Scores by Curriculum

Interest Question	*M*		*SD*	
	Overt[a]	Embedded[b]	Overt[a]	Embedded[b]
Likelihood of applying for a job in the mental health field	2.48	2.75	1.18	1.21
Interest in pursuing a career in the mental health field	2.73	3.08	1.09	1.12

Note. Questions were measured on a Likert-scale (1 = very unlikely, very uninterested, 5 = very likely, very interested).
[a](n = 40). [b](n = 75).

Table 5

Descriptive Statistics of OMI for Psychosocial Fieldwork

OMI Factor	*M*		*SD*	
	With Fieldwork[a]	Without Fieldwork[b]	With Fieldwork[a]	Without Fieldwork[b]
A - Authoritarianism	2.10	2.17	0.44	0.45
B – Benevolence	2.08	2.19	0.39	0.40
C – Mental Hygiene Ideology	3.84	3.98	0.67	0.68
D – Social Restrictiveness	2.54	2.49	0.48	0.56
E – Interpersonal Etiology	2.03	2.00	0.52	0.52

[a](n = 38). [b](n = 77).

Table 6

Independent samples t-test of OMI Factors for Psychosocial Fieldwork

OMI Factor	$t(113)$	p[a]
A - Authoritarianism	0.81	.42
B – Benevolence	1.36	.18
C – Mental Hygiene Ideology	1.06	.29
D – Social Restrictiveness	-0.46	.65
E – Interpersonal Etiology	-0.31	.76

[a]Two-tailed.

Table 7

Descriptive Statistics of Interest Scores for Psychosocial Fieldwork

Interest Question	*M*		*SD*	
	With Fieldwork [a]	Without Fieldwork [b]	With Fieldwork [a]	Without Fieldwork [b]
Likelihood of applying for a job in the mental health field	3.55	2.21	1.06	1.00
Interest in pursuing a career in the mental health field	3.79	2.55	0.93	0.97

[a](n = 38). [b](n = 77).

Table 8

Correlations Between Age and Interest Questions and OMI Factors

	Applying for a job	Interest in a career	Factor A	Factor B	Factor C	Factor D	Factor E
Age	-.05	-.05	-.12	-.02	.21*	-.04	-.12

*$p < .05$, two-tailed.

Table 9

Correlations Between OMI Factors and Interest Questions

	Factor A	Factor B	Factor C	Factor D	Factor E
Applying for a job	-.10	-.27**	.00	-.14	.02
Interest in a career	-.07	-.19*	-.02	-.11	.06

*$p < .05$, two tailed. **$p < .01$, two-tailed.

Appendix B

ALL COLLEGE REVIEW BOARD
FOR
HUMAN SUBJECTS RESEARCH

COVER PAGE

Investigator: Deborah Ferris, Occupational Therapy Graduate Student
Department: Occupational Therapy Department
Telephone: (607) 269-0595
Project Title: The Effect of Occupational Therapy Curriculum on Students' Attitudes Toward Individuals with Mental Illness

Abstract: (Limit to the space provided)

Occupational therapy is just one of the many health professions that provides services for individuals with mental illness. However, the number of occupational therapists working in the mental health field has declined over the past several decades for a variety of reasons, including the attitudes toward mental illness held by new graduates. The structure and content of occupational therapy curricula is designed to foster positive attitudes through the acquisition of knowledge and clinical experience that provides students contact with individuals with disabilities. This study compares the effect of two different educational curricula on occupational therapy students' attitudes toward individuals with mental illness and interest in pursuing a degree in the psychiatric field. Information on occupational therapy programs' curricula, such as curriculum structure and course descriptions, will be gathered through the colleges' Internet web pages. Programs will be classified into two categories depending on whether psychosocial occupational therapy interventions are addressed within a broad adult course or within a specific treatment course covering that topic only. Participants in the study will include occupational therapy students from Ithaca College, as well as three additional occupational therapy programs in the northeast region of the United States. A demographic survey and the Opinions About Mental Illness Scale (OMI) will be used to gather data on student attitudes and perspectives of the psychiatric field. The results of this study will help educators and current occupational therapy practitioners understand the trends in students' attitudes toward mental illness, in addition to providing provide guidance for occupational therapy program development and curricula design.

Proposed Date of Implementation: December 15, 2001

Deborah Ferris, Graduate Student Marilyn Kane, OTR/L, Faculty Advisor
Print or Type Name of Principal Investigator and Faculty Advisor

Signature (Use blue ink) Principal Investigator and Faculty Advisor
ALL COLLEGE REVIEW BOARD

FOR
HUMAN SUBJECTS RESEARCH

CHECKLIST

Project Title: The Effect of Occupational Therapy Curriculum on Students' Attitudes Toward Individuals with Mental Illness
Investigator: Deborah Ferris, Graduate Student

Investigator Use	HSR Use Only	Items for Checklist
_____	_____	1. General information
_____	_____	2. Related experience of investigator(s)
_____	_____	3. Benefits of the study
_____	_____	4. Description of subjects
_____	_____	5. Description of subject participation
_____	_____	6. Description of ethical issues/risks of participation
_____	_____	7. Description of recruitment of subjects
_____	_____	8. Description of how anonymity/ confidentiality will be maintained
_____	_____	9. Debriefing statement
_____	_____	10. Compensatory follow-up
_____	_____	11. Appendix A – Recruitment Statement
_____	_____	12. Appendix B – Informed Consent Form (or tear off) Cover Page for anonymous paper and pen/pencil surveys
_____	_____	13. Appendix C – Debriefing Statement
_____	_____	14. Appendix D – Survey Instruments
_____	_____	15. Appendix E – Glossary to questionnaires, etc.

Items 1-8, 11, and 12 must be addressed and included in the proposal. Items 9, 10, and 13-15 should also be checked if they are appropriate – indicate "NA" if not appropriate. This should be the second page of the proposal.

Ithaca College
Human Subjects Proposal

1. **General Information about the Study**
   a) Funding: The occupational therapy department may distribute funds to pay fees for the use of the survey tool and the cost of copying. There is no external funding being used to conduct this study.
   b) Location: Surveys will be presented to students within the occupational therapy program at Ithaca College, in addition to three other occupational therapy programs in the northeast region of the United States.
   c) Time Period: Initial contact with occupational therapy departments other than Ithaca College will begin in December 2001. Data collection at both Ithaca College and another participating program will occur during January 2002. Data analysis will begin in the spring semester of 2002 following the completion of data collection and will continue until completed.

2. **Related Experience of the Researcher:**

The principal investigator, Deborah Ferris, is currently enrolled as a graduate student in the occupational therapy program at Ithaca College. In the spring of 2001, she received a Bachelor of Science degree in Occupational Science after completing four years of undergraduate work. Her research background includes related coursework covered during Statistics (313-24300), Research Seminar (672-49500), and Research Methods (673-67000). The topics covered in these courses included data analysis and interpretation, reading and analyzing research, and options for designing research studies

Marilyn Kane, the faculty advisor for this study, is an assistant professor in the occupational therapy department. She has been an occupational therapist for approximately 30 years. She has been involved in assessment tool and program development (Functional Needs Assessment for Chronic Psychiatric Patients), and associated analysis of the tool/program effectiveness with that population. She has successfully supervised two graduate theses in the research process.

3. **Benefits of the Study:**

This study will benefit the profession of occupational therapy, as well as occupational therapy educational programs. The knowledge gained through this study will help occupational therapy educators to understand the trends in students' attitudes toward mental illness and psychosocial practice and the impact they may be having on the mental health field. The results of the study may also provide guidance for occupational therapy program development and curriculum design. The profession of occupational therapy will also benefit from this study by examining a possible cause of the decline in the number of therapists working in the mental health field. There is no direct benefit to the occupational therapy students that participate in this study except their understanding that their participation could influence the education process.

4. **Description of Subjects:**

The subjects of the study will be occupational therapy students from Ithaca College, as well as three other occupational therapy programs in the northeast region of the United States. Students enrolled in their graduate year of study will be part of the study. The participating students are expected to be age 18 and over. The number of students participating in the study will vary based on the enrollment numbers in the occupational therapy programs surveyed. Approximately 120 students are anticipated to participate in the study.

5. **Description of Subject Participation:**

After receiving permission from the department chairs of the occupational therapy departments involved in the study, the principal investigator will visit each class participating to present the surveys. Students will be introduced to the purpose of the study through an explanation provided by the principal researcher and a recruitment statement (Appendix A_2). The students will then be presented with an informed consent form (Appendix B) and two surveys (Appendix D_1, and D_2.). The surveys used to gather data are the Participant Demographic Survey (Appendix D_1) and the Opinions About Mental Illness Scale (OMI) (Appendix D_2). The participants' names will not appear anywhere on the surveys. Each survey will be coded and corresponding numbers will be used with the two tools to compare the surveys. Students that agree to participate in the study will be asked to sign and return the informed consent form to an envelope and return the completed surveys in a drop box. The principal researcher will leave the room after giving instructions so that she does not observe which students agree to participate. The survey tools should take approximately 20 to 30 minutes to complete.

6. **Ethical Issues-Description:**

This research study will be conducted in a survey format to increase the level of anonymity for the participants. Although there is little risk associated with the surveys, the questions included in the survey tools may be uncomfortable for some students to answer. Students may hesitate to answer truthfully because of expectations put on them from their chosen profession and other students.

a) Minimizing Risk: The identity of the students that participate in the study will be unknown to the researcher. Students that participate in the study will be informed that their names will not appear on the surveys and that their identity as a participant will not be released. The researcher will inform the students prior to beginning the surveys that any questions that cause discomfort or anxiety can be left blank.
b) Informed Consent: Students agreeing to participate in the study will be asked to read, sign, and return an informed consent form. A copy of the form is found in Appendix B.

7. **Recruitment of Subjects:**

The researcher will contact the department chairs of the occupational therapy programs being asked to participate in the study. The conversation will include the researcher presenting information about the study found in the

recruitment speech (Appendix A_1). Once permission has been received from the department chairs to proceed with the study, the researcher will set up a time convenient with each department to visit the school in order to gather the data. The surveys will be completed in a group setting. The principal researcher will be present during each distribution of the surveys to explain the purpose of the study and to provide consistent instructions. Students will receive the explanation from the researcher as well as a recruitment statement (Appendix A) explaining the project and the benefits of the research to encourage participation in the study. Students will then be asked to read and sign the informed consent form if they wish to participate.

8. **Confidentiality/Anonymity of Responses:**

In order to maintain anonymity and confidentiality, no identifying information will appear on the surveys. The identities of the participants will be unknown to the researcher by using coded forms and having the surveys returned to a drop box after the researcher has left the room. The students will return a signed informed consent form to a separate envelope than the survey results. The signed informed consent forms will be kept under lock and key in the faculty advisor's office to ensure the protection of the participants' identities.

9. **Debriefing:** No debriefing statement is necessary. The students will be fully informed of the purpose of the study prior to agreeing to participate.

10. **Compensatory Follow-up:** No negative outcomes are predicted due to participation in the study so compensatory follow-up will not be necessary.

11. All required appendices are attached, and include:
    a) Appendix A_1: Recruitment Speech
    b) Appendix A_2: Recruitment Statement
    c) Appendix B: Informed Consent Form
    d) Appendix D_1: Participant Demographic Survey
    e) Appendix D_2: Opinions About Mental Illness Scale (OMI)

Appendix C

Participant Demographic Survey

Directions:

The following questions are designed to learn about the characteristics of the individuals who choose to participate in this study. Please answer the questions by circling or filling in the appropriate response.

1. Age _____

2. Gender: Female Male

3. Have you completed a Level II **Psychosocial** Fieldwork in a mental health or psychiatric setting?

Yes No

If yes, please briefly describe the population (ex: age range and diagnoses) and interventions.

4. What is your personal experience with mental illness? (circle all that apply)

a. Family member with mental illness
b. Friend with mental illness
c. Contact with community members with mental illness
d. No contact with a person with mental illness
e. Other: _____

5. How likely are you to apply for a job in the mental health/psychiatric field following the completion of your degree?

a. Very likely
b. Likely
c. Not sure
d. Unlikely
e. Very unlikely

6. What is your interest in the pursuing a career in the mental health/psychiatric field?

a. Extremely interested
b. Interested
c. Not sure
d. Uninterested
e. Extremely uninterested

OPINIONS ABOUT MENTAL ILLNESS SCALE

Directions:

The statements that follow are opinions or ideas about mental illness and individuals with mental illness. By mental illness, we mean the kinds of illness that requires hospitalization, and by individuals with mental illness we mean those persons who have been hospitalized for mental illness. 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 the statements. We would like to know you think about these statements. Each of them is followed by six choices:

Strongly _____ agree	Agree _____	Not sure _____ but probably agree	Not sure _____ but probably disagree	Disagree _____	Strongly _____ 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.

Please **DO NOT** sign your name.

---

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

Strongly _____ agree	Agree _____	Not sure _____ but probably agree	Not sure _____ but probably disagree	Disagree _____	Strongly _____ disagree

2. Mental illness is an illness like any other.

Strongly _____ agree	Agree _____	Not sure _____ but probably agree	Not sure _____ but probably disagree	Disagree _____	Strongly _____ disagree

3. Most patients hospitalized for mental illness are not dangerous.

Strongly _____ agree	Agree _____	Not sure _____ but probably agree	Not sure _____ but probably disagree	Disagree _____	Strongly _____ disagree

4. Although patients hospitalized for mental illness may seem all right after being discharged, they should not be allowed to marry.

Strongly _____ agree	Agree _____	Not sure _____ but probably agree	Not sure _____ but probably disagree	Disagree _____	Strongly _____ disagree

5. If parents loved their children more, there would be less mental illness.

Strongly agree _____ Agree _____ Not sure but probably agree _____ Not sure but probably disagree _____ Disagree _____ Strongly disagree _____

6. It is easy to recognize someone who once had a serious mental illness.

Strongly agree _____ Agree _____ Not sure but probably agree _____ Not sure but probably disagree _____ Disagree _____ Strongly disagree _____

7. People who are mentally ill let their emotions control them: other people think things out.

Strongly agree _____ Agree _____ Not sure but probably agree _____ Not sure but probably disagree _____ Disagree _____ Strongly disagree _____

8. People who were once hospitalized for mental illness are not more dangerous than the average citizen.

Strongly agree _____ Agree _____ Not sure but probably agree _____ Not sure but probably disagree _____ Disagree _____ Strongly disagree _____

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.

Strongly agree _____ Agree _____ Not sure but probably agree _____ Not sure but probably disagree _____ Disagree _____ Strongly disagree _____

10. Although they usually aren't aware of it, many people become mentally ill to avoid the difficult problems of everyday life.

Strongly agree _____ Agree _____ Not sure but probably agree _____ Not sure but probably disagree _____ Disagree _____ Strongly disagree _____

11. There is something about individuals with mental illness that makes it easy to tell them from other people.

Strongly agree _____ Agree _____ Not sure but probably agree _____ Not sure but probably disagree _____ Disagree _____ Strongly disagree _____

12. Even though patients hospitalized for mental illness behave in funny ways, it is wrong to laugh about them.

Strongly agree _____ Agree _____ Not sure but probably agree _____ Not sure but probably disagree _____ Disagree _____ Strongly disagree _____

13. Most individuals with mental illness are willing to work.

Strongly agree _____ Agree _____ Not sure but probably agree _____ Not sure but probably disagree _____ Disagree _____ Strongly disagree _____

14. The small children of patients hospitalized for mental illness should not be allowed to visit them.

Strongly agree _____ Agree _____ Not sure but probably agree _____ Not sure but probably disagree _____ Disagree _____ Strongly disagree _____

15. People who are successful in their work seldom become mentally ill.

Strongly agree _____ Agree _____ Not sure but probably agree _____ Not sure but probably disagree _____ Disagree _____ Strongly disagree _____

16. People would not become mentally ill if they avoided bad thoughts.

Strongly agree _____ Agree _____ Not sure but probably agree _____ Not sure but probably disagree _____ Disagree _____ Strongly disagree _____

17. Patients hospitalized for mental illness are in many ways like children.

Strongly agree _____ Agree _____ Not sure but probably agree _____ Not sure but probably disagree _____ Disagree _____ Strongly disagree _____

18. More tax money should be spent in the care and treatment of people with severe mental illness.

Strongly agree _____ Agree _____ Not sure but probably agree _____ Not sure but probably disagree _____ Disagree _____ Strongly disagree _____

19. A heart patient has just one thing wrong with him, while a person with mental illness is completely different from the other patients.

Strongly agree _____ Agree _____ Not sure but probably agree _____ Not sure but probably disagree _____ Disagree _____ Strongly disagree _____

20. Individuals with mental illness come from homes where the parents took little interest in their children.

Strongly agree _____ Agree _____ Not sure but probably agree _____ Not sure but probably disagree _____ Disagree _____ Strongly disagree _____

21. People with mental illness should never be treated in the same hospital with people with physical illness.

Strongly agree _____ Agree _____ Not sure but probably agree _____ Not sure but probably disagree _____ Disagree _____ Strongly disagree _____

22. Anyone who tries to better himself deserved the respect of others.

Strongly agree _____ Agree _____ Not sure but probably agree _____ Not sure but probably disagree _____ Disagree _____ Strongly disagree _____

23. If our hospitals had enough well-trained doctors, nurses, and aides, many of patients hospitalized for mental illness would get well enough to live outside the hospital.

Strongly agree _____ Agree _____ Not sure but probably agree _____ Not sure but probably disagree _____ Disagree _____ Strongly disagree _____

24. A woman would be foolish to marry a man who had a severe mental illness, even though he seems fully recovered.

Strongly agree _____ Agree _____ Not sure but probably agree _____ Not sure but probably disagree _____ Disagree _____ Strongly disagree _____

25. If the children of mentally ill parents were raised by other parents, they would not become mentally ill.

Strongly agree _____ Agree _____ Not sure but probably agree _____ Not sure but probably disagree _____ Disagree _____ Strongly disagree _____

26. People who have been hospitalized for mental illness will never be their old selves again.

Strongly agree _____ Agree _____ Not sure but probably agree _____ Not sure but probably disagree _____ Disagree _____ Strongly disagree _____

27. Many individuals with mental illness are capable of skilled labor, even though in some ways they are very disturbed mentally.

Strongly agree _____ Agree _____ Not sure but probably agree _____ Not sure but probably disagree _____ Disagree _____ Strongly disagree _____

28. Our mental hospitals seem more like prisons than like places where individuals with mental illness can be cared for.

Strongly agree _____ Agree _____ Not sure but probably agree _____ Not sure but probably disagree _____ Disagree _____ Strongly disagree _____

29. Anyone who is hospitalized for a mental illness should not be allowed to vote.

Strongly agree _____ Agree _____ Not sure but probably agree _____ Not sure but probably disagree _____ Disagree _____ Strongly disagree _____

30. The mental illness of many people is caused by the separation or divorce of their parents during childhood.

Strongly agree _____ Agree _____ Not sure but probably agree _____ Not sure but probably disagree _____ Disagree _____ Strongly disagree _____

31. The best way to handle patients hospitalized for mental illness is to keep them behind locked doors.

Strongly agree _____ Agree _____ Not sure but probably agree _____ Not sure but probably disagree _____ Disagree _____ Strongly disagree _____

32. To become a patient hospitalized for mental illness is to become a failure in life.

Strongly agree _____ Agree _____ Not sure but probably agree _____ Not sure but probably disagree _____ Disagree _____ Strongly disagree _____

33. The patients hospitalized for mental illness should be allowed more privacy.

Strongly agree _____ Agree _____ Not sure but probably agree _____ Not sure but probably disagree _____ Disagree _____ Strongly disagree _____

34. If a patient hospitalized for mental illness attacks someone, he should be punished so he doesn't do it again.

Strongly _____ Agree _____ Not sure _____ Not sure _____ Disagree _____ Strongly _____
agree but probably but probably disagree
agree disagree

35. If parents with mental illness raised the children of other people, the children would probably become mentally ill.

Strongly _____ Agree _____ Not sure _____ Not sure _____ Disagree _____ Strongly _____
agree but probably but probably disagree
agree disagree

36. Every psychiatric hospital should be surrounded with a high fence and guards.

Strongly _____ Agree _____ Not sure _____ Not sure _____ Disagree _____ Strongly _____
agree but probably but probably disagree
agree disagree

37. The law should allow a woman to divorce her husband as soon as he has been indefinitely hospitalized with a severe mental illness.

Strongly _____ Agree _____ Not sure _____ Not sure _____ Disagree _____ Strongly _____
agree but probably but probably disagree
agree disagree

38. People (both veterans and non-veterans) who are unable to work because of mental illness should receive money for living expenses.

Strongly _____ Agree _____ Not sure _____ Not sure _____ Disagree _____ Strongly _____
agree but probably but probably disagree
agree disagree

39. Mental illness is usually caused by some disease of the nervous system.

Strongly _____ Agree _____ Not sure _____ Not sure _____ Disagree _____ Strongly _____
agree but probably but probably disagree
agree disagree

40. Regardless of how you look at it, patients with severe mental illness are no longer really human.

Strongly _____ Agree _____ Not sure _____ Not sure _____ Disagree _____ Strongly _____
agree but probably but probably disagree
agree disagree

41. Most women who were once hospitalized for mental illness could be trusted as baby sitters.

Strongly agree	Agree	Not sure but probably agree	Not sure but probably disagree	Disagree	Strongly disagree
_____	_____	_____	_____	_____	_____

42. Most patients hospitalized for mental illness don't care how they look.

Strongly agree	Agree	Not sure but probably agree	Not sure but probably disagree	Disagree	Strongly disagree
_____	_____	_____	_____	_____	_____

43. College professors are more likely to become mentally ill than are business men.

Strongly agree	Agree	Not sure but probably agree	Not sure but probably disagree	Disagree	Strongly disagree
_____	_____	_____	_____	_____	_____

44. Many people who have never been hospitalized for mental illness are more mentally ill that many hospitalized individuals with mental illness.

Strongly agree	Agree	Not sure but probably agree	Not sure but probably disagree	Disagree	Strongly disagree
_____	_____	_____	_____	_____	_____

45. Although some individuals with mental illness seem all right, it is dangerous to forget for a moment that they are mentally ill.

Strongly agree	Agree	Not sure but probably agree	Not sure but probably disagree	Disagree	Strongly disagree
_____	_____	_____	_____	_____	_____

46. Sometimes mental illness is punishment for bad deeds.

Strongly agree	Agree	Not sure but probably agree	Not sure but probably disagree	Disagree	Strongly disagree
_____	_____	_____	_____	_____	_____

47. Our psychiatric units of hospitals should be organized in a way that makes the patient feel as much as possible like he is living at home.

Strongly agree	Agree	Not sure but probably agree	Not sure but probably disagree	Disagree	Strongly disagree
_____	_____	_____	_____	_____	_____

48. One of the main causes of mental illness is a lack of moral strength or will power.

Strongly agree	Agree	Not sure but probably agree	Not sure but probably disagree	Disagree	Strongly disagree
_____	_____	_____	_____	_____	_____

49. There is little that can be done for patients hospitalized for mental illness except to see that they are comfortable and well-fed.

Strongly agree	Agree	Not sure but probably agree	Not sure but probably disagree	Disagree	Strongly disagree
_____	_____	_____	_____	_____	_____

50. Many individuals with mental illness would remain in the hospital until they were well even if the doors were unlocked.

Strongly agree	Agree	Not sure but probably agree	Not sure but probably disagree	Disagree	Strongly disagree
_____	_____	_____	_____	_____	_____

51. All patients hospitalized for mental illness should be prevented from having children by a painless operation.

Strongly agree	Agree	Not sure but probably agree	Not sure but probably disagree	Disagree	Strongly disagree
_____	_____	_____	_____	_____	_____

Appendix D

Recruitment Statement

I am asking you to participate in a research study I am conducting in order to fulfill the requirements for my master's degree in Occupational Therapy from Ithaca College. This study is investigating the attitudes of occupational therapy graduate students toward individuals with mental illness and perspectives of the mental health field. This research will help occupational therapy practitioners and educators understand the trends in student attitudes toward mental illness.

Included in this packet are an informed consent form and two surveys. Please take the time to read through the informed consent form and sign it prior to completing the surveys. Return the signed consent form and the completed surveys to the envelopes in the front of the room. The survey forms should take approximately 20 minutes to complete.

Thank you for your cooperation with this study. If you have any questions or concerns regarding the study please feel free to contact me at (607) 269-0595 or dferris1@ic3.ithaca.edu.

Deborah Ferris, BS, OTS
Telephone: (607) 259-0595
E-mail: dferris1@ic3.ithaca.edu

Appendix E

INFORMED CONSENT FORM

The Effect of Occupational Therapy Curriculum on Students' Attitudes Toward Individuals with Mental Illness

1. Purpose of the Study:
   This study is being conducted to investigate the current attitudes of occupational therapy students toward mental illness. Researching student attitudes is an important element in understanding trends in the professional field.

2. Benefits of the Study:
   Educators will benefit from this study by understanding the attitudes that students have toward mental illness and addressing them in coursework. As a result, educators will more effective in promoting the types of attitudes that are essential for future occupational therapists to have before entering the field.

3. What You Will Be Asked To Do:
   If you agree to participate in this study, you will complete two surveys. One will involve questions about yourself and the other will ask you to rate your feelings on statements about mental illness. These surveys each have their own set of directions and should take no longer than 20 minutes to complete.

4. Risks:
   There should be no risks involved in participating in this study. Although unlikely, you may feel uncomfortable answering some of the questions. Please feel free to leave any questions blank that you do not feel comfortable answering. Also, you are assured that your answers will remain completely anonymous and that your identity as a participant will not be revealed in any way.' services may be affected by your responses. If your participation in this study causes any concern please let your professor or myself know or feel free to contact me, Deborah Ferris, in the future at (607) 269-0595.

5. If You Would Like More Information about the Study:
   If you have any questions or concerns that arise prior to or after your participation in this study, please feel free to contact Deborah Ferris at 607-269-0595, or email me at dferris1@ic3.ithaca.edu.

6. Withdrawal From the Study:
   Participating in this study is voluntary. As a participant, you have the right to refuse to answer any survey questions that you feel uncomfortable about. You may withdraw from this study at any time during administration without any penalty. If you wish to keep your decision to withdraw from the study confidential, please return the unanswered forms to the same envelope and drop box as the completed ones.

7. How the data will be maintained in confidence:
   In order to ensure your confidentiality, no identifying information will appear on the completed surveys. The informed consent form will only be seen by the researcher and the faculty advisor working on the project.

I have read the above and I understand its contents. I agree to participate in the study. I acknowledge that I am 18 years of age or older. Please sign and date this form to give your consent to participate in this study and return it to the collection envelope. Please do not put your name anywhere on the surveys. Thank you for you participation in this study.

_____
Print Name

_____ _____
Signature Date