

THE PLACE OF PSYCHIATRY IN POPULAR THINKING

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I suppose everyone here already knows that NORC has a mental health survey nearing completion--after all, it's been nearing completion for five or six years, now. I'm not going to dwell on this. I only mention it in order to say that my remarks today are more or less based on data derived from intensive interviews (about an hour and a half's duration) with a national sample (modified area-probability type) of just over thirty-five hundred adults. The interviewing was carried out in May and June, 1950; the code in terms of which the interview material is classified and analyzed covers 476 pages; at the moment, we have 16 IBM cards per interview--nine cards cover the original data coded, the other seven represent a variety of constructed summaries and indices, with one or two more cards still to come before the analysis is completed. Obviously, it isn't simple, and I'm not going to pretend to cover the full range of the study or even all of the data which bear on my subject for today.

Now then, what about psychiatry in popular thinking? To simplify things, let me talk first about psychiatrists or the profession of psychiatry, as distinct from the ideas and theories usually identified with the field. Well, in a series of questions dealing primarily with the treatment and prevention of mental illness--"nervous conditions" and "insanity," that is--73 per cent spontaneously mentioned persons who can roughly be classified as belonging to the profession of psychiatry as logical sources of help. Their terminology was not always so precise, of course, but, in fact, just over half of the public (53%) were able to produce the word, "psychiatrist," with--we hope--no coaching from the interviewer, while the rest (20%) mostly talked about head doctors, mind doctors and nervous doctors.

So, I think from this simple set of figures two things are already apparent: first, that most people knew that the field of psychiatry exists and knew further that it specializes in the treatment of mental illness, and second, that a large majority had no great quarrel with this state of affairs. For instance, when we asked people, later on, how serious a problem a person should have before he goes to see a psychiatrist, we got the same kind of matter-of-fact approach: only nine per cent were unable to answer this question, and only five per cent said anything negative about psychiatry in this context. The rest offered a great variety of answers, but they all boiled down to one thing; namely, that a person should go to see a psychiatrist whenever he is in need of psychiatric treatment.

So, here we have data strongly implying a quite wide-spread and matter-of-fact acceptance of the profession of psychiatry, but it is largely a simple acknowledgment of a fact, made quite irrespective of the person's feelings about psychiatry. That is, where we have non-circular evidence that people knew of the existence of psychiatry--and I'm using here the sub-group of people who could give

some description of psychiatric methods in answer to a later direct question, we find that, even among those who were explicitly hostile, opposed or critical of psychiatry, 80 per cent had nevertheless spontaneously suggested psychiatry as a treatment source.

So, if you'll accept that the public largely knew that psychiatry exists and acquiesced in its existence, we can move on to a more interesting point. Because actually, the more noteworthy thing about popular reactions to the profession of psychiatry was a vast indifference, which for all practical purposes constituted rejection. I'll try to sketch in three of the main lines of evidence for that statement.

1. First, psychiatry was remote and unfamiliar for most people. For a variety of reasons, people almost invariably associated the practice of psychiatry with the treatment of non-institutionalized patients rather than with mental hospitals. Now, very few people had had any first- or second-hand contact with office psychiatry, if I may use that phrase. Only 23 per cent of the public reported even the slightest acquaintance with someone who had been treated by a psychiatrist outside hospital walls, and those who did were more likely to be referring to people they didn't know well than to intimates.

The upshot was that people didn't know very much about the kind of psychiatry they were trying to talk about. When we asked, for instance, "As far as you know, how does a psychiatrist go about helping the people who come to him?", and followed that with a number of probes, two-fifths of the public couldn't even make a stab at answering the question; and another fifth were quite vague in what they said. Even where people did say something specific about the practice of psychiatry, they frequently studded their comments with direct and indirect expressions of their own feelings of uncertainty about their knowledge like, "I haven't the least idea, but according to what I've seen in the movies..." or "I imagine they would..." and so on. If we combine the people with no information, those with vague information and those who acknowledged the speculativeness of what they were saying, we come out with at least 73 per cent of the people rather shakily informed.

2. Now, second, and maybe it's only another way of saying the same thing, relatively few people thought of psychiatry as something which had any relevance for themselves or for the kind of people they knew. That is, the average American adult had never known anyone who had been helped by seeing a psychiatrist, he could think of no one in his acquaintance who would benefit from seeing a psychiatrist and he had no interest, however remote or of whatever kind, in seeing a psychiatrist himself. Exactly three-fifths of the public gave negative answers to all three of the questions I've just implied. Now this may strike you, as it did me, as a pretty remarkable result, because I think I'm safe in assuming--without turning this meeting into a kind of confessional quiz--that practically everyone of us would have given positive answers to all three--that is, we all know people who've been successfully treated, it's practically a cliché in our circles to say that so-and-so really ought to see a psychiatrist, and most of us would agree that it would be pretty darn interesting to see what psychiatric treatment is like first-hand, even if we might not be so willing to acknowledge that there's any actual need for it. I stress all this, because the plain fact is that we, here, live in a kind of psychiatrically-oriented sub-culture and, so far as I've been able to estimate--for instance, if you'll accept those three "yeses" as a kind of definition of the psychiatrically-oriented sub-culture--that equals approximately three per cent of the American population.

3. Now third, and finally, and again it almost follows from the two preceding points, there was, so far as we could discover, relatively little affect about the topic of psychiatry, and it would be strange indeed if a topic as remote, unfamiliar and irrelevant as psychiatry has just appeared to be, generated very much heat. I have to be a little tentative here, because we didn't ask any questions directly calling for an expression of attitude toward psychiatry. But with a large series of questions which invited people to talk about psychiatry, 69 per cent of the public went through the interview without making any emotionally-toned statements about psychiatry. Now, in the light of many supporting data, this actually is a depiction of the true state of affairs. Otherwise, I don't know how to explain the data we did get. For instance, when we asked if the respondent had any interest in seeing a psychiatrist, thinking that this, surely, would require a person to indicate implicitly or explicitly, how he felt about psychiatry, most people took it simply as a query into their own state of mental health and answered with resounding "no's" on the simple and pragmatic grounds that they had no need for treatment. Out of the entire sample, 86 per cent made sure that they got their denial of need on the record, but only 20 per cent based their answers to any degree on anything about the nature of psychiatry or their reactions to it. So I feel we have to say that there is plenty of affect surrounding the subject of mental illness, but psychiatry, which is seen simply as the automatic sequel to mental illness, doesn't awaken much independent affect of its own.

Well, then, if I can summarize what I've said so far in an oversimplified way, the typical reaction to psychiatry is that anybody who needs psychiatric treatment should see a psychiatrist, but that practically no one ever needs psychiatric treatment. If you focus only on the first statement, there's public acceptance of psychiatry, but the sphere in which psychiatry was thought relevant and permitted to operate with this full acceptance was so constricted that we might as well call it public rejection of psychiatry.

Now, in order to state this more quantitatively, I've constructed a summary index of people's acceptance of the profession of psychiatry. Since it plays a crucial role from now on, I'll have to describe it in detail. To start with, the 31 per cent who expressed feelings about psychiatry are taken at their word. This gives us three per cent who repudiated psychiatry completely and out of hand, as entirely unsound and worthless, as for instance, this respondent who said--he had been asked how serious a problem a person should have before he goes to a psychiatrist about it--"I don't think I'd have to go to anybody to tell me I was crazy, hold my hand and talk to me for twenty dollars an hour. A person does that, they really are crazy. If they didn't have any more sense than to go to a psychiatrist they ought to be put in a nut house." Then there were about seven per cent who were equally critical of the very foundations of psychiatry, but reluctantly admitted that there might be extreme circumstances where one had to traffic with the devil. The rest of the hostility--and that's 19 per cent of the total population--was more in the nature of what might be called resistance--people didn't go so far as to say psychiatry was unsound, useless, wrong, dangerous or what have you, they simply said either that it was personally unpalatable, or threatening to their conceptions of themselves and, so, something they'd rather have no truck with, or they expressed even more diffuse uneasiness about it--was it really entirely respectable, weren't the fees inordinate for the services rendered, couldn't all that introspection make a person worse in some cases than he was to begin with, and so on.

So, ignoring fine distinctions, we have 29 per cent who were unhappy with psychiatry to some degree, and then there are two per cent who voiced hearty approval of or even enthusiasm for psychiatry. The rest, you recall, is silence,

but we took the remaining 69 per cent and split them in two. One group, equalling 39 per cent, is made up of people who never gave any sign that psychiatry had any personal relevance; that is, they said no to those three questions--they didn't know anyone who was helped, they didn't know anyone who could be helped and they had no interest in it for themselves. So this is a group we call implicitly rejecting, since their avoidance of psychiatry was not accompanied by any overt hostility. That leaves, of course, 30 per cent who answered "Yes" to at least one of those three questions, and these we call the implicitly accepting. (I might as well say now that a great deal of soul-searching went into this classification and, if anything, it overstates the amount of acceptance. For instance, some 10 per cent of the population are classified as accepting simply because they said someone they knew needed to see a psychiatrist, which may simply represent the most scathing thing they could find to say about the person under discussion rather than an endorsement of psychiatry, but we had no further evidence to use in deciding when it was the one and when the other, so we took it all as implying acceptance.) Anyhow, rough as it is, we end up with 29 per cent hostile, 39 per cent rejecting and 32 per cent accepting, combining the two per cent vocally approving into this last group.

In any case, the exact figures aren't terribly important; just think of it as a very rough index of public acceptance of the profession of psychiatry, based on those portions of the interview where respondents were talking about psychiatrists and knew that they were. What I want to do with it is to demonstrate one single truth; namely, that the acceptance of the profession of psychiatry is, in the last analysis, largely a matter of acceptance of a way of thinking about behavior, especially as it applies to mental illness. Psychiatry, I intend to show, has little public acceptance because its way of thinking is alien to and incompatible with popular thinking.

To document this sweeping statement, I'm switching away from talking about psychiatry as a well-defined medical specialty constituted by a definite group of people who practice it, to psychiatry as a more diffuse, but rather consistent, intellectual tendency of our times. That is, I'm thinking of psychiatry as the source--whether the people influenced by it are aware of it or not--of a particular orientation toward human behavior and its relation to mental illness, a point of view which is, in large measure, disseminated by the mental health education field, today. Now, I suppose it's possible to debate whether I have any right to talk about the psychiatric orientation, when psychiatry is a field shot through with divisions and dissensions. It's possible, but I don't intend to embroil myself at this point. I think it will become clear as I go along that I'm talking about such primitive elements that they do constitute a common substratum to all schools of psychiatry that purport to deal with human behavior. If not, we can argue later. (I should add, however, that nothing I'm about to say is applicable to that portion of psychiatric practice which does approximate a pure medical specialty; that is, I'm excluding that part of the field where psychiatrists function as medical specialists in diseases of the nervous system.)

Now, what do I mean when I talk about the psychiatric orientation or, for that matter, any kind of orientation in the mental health field? In brief, I mean only that there is a set of interrelated premises about human behavior--that is, primarily, premises about the determinants of human behavior and about its control--which leads to a consistent set of conclusions about mental illness; these conclusions being roughly what we mean when we talk about conceptions of mental illness, and so, covering both definitions of mental illness or principles for classifying behavior as mental illness or not and the beliefs, attitudes, feelings, and so on which are addressed to the category of mental illness. Notice, please, that

I'm saying it's a logical system in which premises lead to conclusions; notice, also, that I'm saying that the premises are the crucial element, because, given the premises, the conclusions follow almost inexorably.

This, you may feel, is pretty far afield from survey research, but actually, the heart of our survey--and its most interesting and troublesome-to-analyze section--is concerned exactly with finding out how people do approach human behavior and how this shapes their conceptions of mental illness. To do this, we drew up--at the suggestion and with the help of John Clausen and with a variety of psychiatric advice--a set of character sketches of six individuals whose patterns of behavior we all agreed represented instances that psychiatrists would classify as mental illness and, roughly, might label, respectively, as paranoid schizophrenia, simple schizophrenia, anxiety neurosis, compulsive-phobic disorder, alcoholism, and a childhood behavior disorder, featuring delinquent behavior. These were presented to people and they were asked first, to account for the behavior, to talk about its cause, to tell how, in their view, a person might come to be the way he was presently described. Then we asked respondents to classify the example--was this what they would call mental illness or wasn't it--and, usually, if it wasn't we got some idea of what category people thought it did represent. And, third, we asked people for the logic of their classification, what were they going on in deciding what was mental illness and what wasn't. We asked some other things, too, but these won't concern us.

Now the easiest result to present is that the public generally comes to quite different conclusions than psychiatrists would. We get 17 per cent of the public saying that not one of these imaginary persons is sufficiently deviant to represent what they meant by mental illness and another 28 per cent limiting their concept of mental illness to the one we think of as paranoid, the only instance where violence was a prominent feature in the behavior. At the other extreme, we get two per cent saying all six could be categorized as mentally-ill, a figure, need I point out, not too different from those we arrive at by any other single method of estimating the size of the thoroughly psychiatrically-influenced subculture. This should elucidate why so many people could say that anyone with a mental illness should see a psychiatrist, while at the same time never seeming to encounter a person who needed to see a psychiatrist.

I started with this conclusion about what belongs in the category of mental illness partly because it makes very clear that popular conclusions remain quite different from psychiatric conclusions, even after years of mental health education. But, mainly, I wanted to bring out the point that when we look behind these conceptions of mental illness to the theories of behavior on which they are based, we are, for the most part, dealing with people's approach to behavior, generally, since they didn't usually view the behavior as mental illness, nor did they--let me add categorically--view it as something tantamount to mental illness under some different name.

It's simple enough to see that the psychiatric classification of these examples rests on a definition of the deviant behavior to be called mental illness in terms of its functional or emotional deviancy. Roughly, it might be said that mental illness is defined as those instances in which the dominant behavioral or emotional patterns of the individual are seriously inappropriate or maladaptive to his reality situation. And I think it's obvious also how this definition grows rather naturally out of an approach to human behavior which postulates even the three minimal premises I'm centering on. These are:

First, that--The basic explanatory scheme is presumed to be applicable to all human behavior whether it is ultimately classified as deviant or non-deviant.

Second, that--The ultimate causes of characteristic emotional patterns are usually attributed to early interpersonal experiences rather than to immediate stimuli external to the individual psyche or to deliberate, conscious, individual choices.

And, third, that--Characteristic emotional patterns are, therefore, to be regarded as not entirely within the rational control of the individual and as not easily modifiable. Modifications of behavior patterns which depend entirely on the rationality of the deviant person--on self-help, willpower, appeals to reason, logical exhortation and the like--or on purely environmental alterations are generally perceived to be inadequate to the difficulty.

What's more, given these premises about human behavior, and given a harmonious definition of mental illness, there's another sort of conclusion implicit; namely, that mental illness, so conceived, does not automatically conjure up an image of overwhelming threat, nor equally inevitably, arouse fear, horror and avoidance.

Well, it's just these three simple elements of premises about human behavior, definitions of mental illness, and images of threat that I want to present to you in quantitative fashion. Before doing so, I don't think I need to say much more about the popular approach than that it is, in almost every respect, the diametrical opposite of what I've just attributed to the psychiatric orientation. That is, it is, at base, a normative-rational orientation which starts out to explain normal behavior, not all behavior. It begins from the premise that the distinctive and essential human qualities are rationality and the ability to exercise self-control. Given this premise, normal behavior is viewed as a rational response to the immediate circumstances in which the individual finds himself, which is, at the same time, fully within the conscious control of the person. Mental illness is defined as the extreme opposite of normalcy. It is, therefore, behavior in which rationality is so impaired that the individual has lost control and can no longer be responsible for his acts. Or, in short, and quite logically, it is an extreme form of psychosis and only that. Given this orientation it also follows that mental illness is a very threatening thing. It represents to people loss of the distinctively human qualities, the ultimate catastrophe that can befall a human and there is a horror about dehumanization.

Well, to get back to the data, here's how we've measured--or, more accurately, indexed--all this. We've set up three scores--premises, definitions, and image of threat. The first score, premises, is indexed by two items, first the extent to which the person relied on early interpersonal experiences in explaining the six examples and, second, the extent to which the person relied on rational self-control--willpower--as a sufficient means of changing disordered behavior. Now, each item is scored trichotomously and, I should add, quite arbitrarily. For instance if a person used the category of explanation at least twice, we give him plus one, with the plus defined as in the direction of a psychiatric orientation. If he used it just once, it's neither here nor there, so he gets a 0. If he never used it, which means, essentially, that he relied on explanations in terms of immediate circumstances or of personal choices, he gets a minus one, which means he's in the direction of the normative-rational approach. Similarly, with the self-help item: if it was rarely or never used, he's plus one; if it was used more frequently but never or not always as the sole instrumentality needed to affect change, he's in the middle, and if it was repeatedly cited as the sole and

sufficient means of change he's over in the normative-rational direction. So, these scores run from +2 to -2, with the pluses leaning in the direction of psychiatric premises about human behavior, the minuses leaning the other way. Now I happen to believe the absolute frequencies of these scores don't mean too much, since they're pretty arbitrary, and they're intended to err on the generous side in crediting somebody with a psychiatric orientation. But, if it interests you, we get seven per cent whose scores are as pro-psychiatric as they can get and another 20 per cent with plus one scores, or roughly a quarter with a net balance in the direction of the psychiatric orientation toward human behavior.

Well this is the general idea, so let me describe the other scores more hurriedly and get to the table in your hands. The definition of mental illness score contains three items. A person gets a plus three if he consistently described mental illness over yet another set of questions in a way which included non-psychotic manifestations, and if his classifications of the six examples placed at least the two psychotics and the anxiety neurotic in the category of mental illness, and, if, in explaining his classifications, he at least once referred to the quality of emotional deviancy as an inherent characteristic of mental illness. A minus three, of course, is the opposite pole on these three items: references only to psychoses in describing mental illness, only violent psychosis classed as mental illness from the examples and references only to cognitive-control deviancy--loss of reason or loss of control--in characterizing mental illness. Plus three's here are five per cent; total plus anythings are 33 per cent.

The last score, threat, is simpler. A plus three here believes most psychotics are not dangerous to be around, that most psychotics can make a complete recovery and that he, himself, would act and feel perfectly normally around a former hospital patient. A minus three, conversely says it's dangerous, they mostly don't even improve, and he would react with fear and avoidance. Plus three's here are 13 per cent; all pluses are 44 per cent.

Now, the table that's in your hands, which I've tried to keep obscure until this dramatic moment. Well, what this table is presenting is the percentage within each sub-group who are classified as accepting the profession of psychiatry. As you see up at the top, just as I mentioned much earlier, 32 per cent of the total population are classified as accepting in the sense that they feel psychiatry has been or might be useful to someone they know and had no other opposition. Now, the sub-groups in the first cross-break are simply score groups based on combining the three scores I've just outlined into one total score, so the first group represents people with scores of +8, and so on down to minus 8. So, as you can plainly see for yourself, there's no such thing as accepting the services of the profession of psychiatry as having relevance for your life unless you accept pretty nearly all of the premises about human behavior and conclusions about mental illness that make up the psychiatric approach. (By the way, I wouldn't ordinarily compute percentages on so few cases as I have at the two extremes, but I couldn't resist the temptation of presenting a table where the percentages actually vary all the way from zero to 100 per cent.)

Now the second cross-break nails it down still further by asking what happens if you accept the premises of the psychiatric position but not the conclusions, or vice-versa? So the first three groups are people who lean in the direction of psychiatrically-oriented premises--that is, they get scores of +2 or +1; the last three are those who don't share the premises. Within each premise grouping, the first sub-group accepts five or six of the conclusions, the second, three or four, and the last, two or less. So, you see here that unless the conclusions are a logical outgrowth from appropriate premises, they have no effect

Survey 272--Final Tabulations--The Status of Psychiatry

	Per cent (in Indicated Group) <u>Accepting Psychiatrists</u>	Number of Cases in Group
All cases . . . . .	32	3,531
<u>Degree of Psychiatric Orientation</u>		
3 . . . . .	(100)	10
7 . . . . .	78	36
6 . . . . .	58	62
5 . . . . .	53	108
4 . . . . .	53	159
3 . . . . .	42	264
2 . . . . .	39	326
1 . . . . .	33	432
0 . . . . .	33	394
-1 . . . . .	29	444
-2 . . . . .	24	399
-3 . . . . .	25	322
-4 . . . . .	20	285
-5 . . . . .	16	154
-6 . . . . .	15	99
-7 . . . . .	15	32
-8 . . . . .	( 0)	5
<u>Accepted Psychiatric Premises</u>		
Accepted MOST of the Psychiatric Conclusions . . . . .	74	90
Accepted about HALF of the Psy- chiatric Conclusions . . . . .	49	385
Accepted FEW or NONE of the Psychiatric Conclusions . . . . .	32	502
<u>Did Not Accept Psychiatric Premises</u>		
Accepted MOST of the Psychiatric Conclusions . . . . .	39	118
Accepted about HALF of the Psy- chiatric Conclusions . . . . .	35	759
Accepted FEW or NONE of the Psychiatric Conclusions . . . . .	24	1,677

on acceptance of psychiatry and, similarly, unless the premises lead to compatible conclusions, they have little effect on acceptance. And, though I haven't bothered to present the details, it's clear from the fact that only those with the psychiatric premises and five or six conclusions are predominantly accepting, that both kinds of conclusions--appropriate definition of mental illness and appropriate image of threat --are required.

Now I think the implications of this are so earth-shaking that I wish I had a great deal more time and I wish, even more, that I didn't have to stop for methodological quibblings. There is that hardy perennial objection that maybe this is all a spurious correlation and if I held X, Y or Z constant it would all vanish. Well, 'tain't true. It is a fact that this psychiatrically-oriented subculture is made up predominantly of intellectuals, and urban intellectuals at that; they're college-educated, professionals, and all the correlates of those two. But, whatever objective differences I hold constant, differences like those before you in that table survive.

So, implications. Primarily these results, like the research itself, are addressed to the lay mental health field and not to the profession of psychiatry, except of course as psychiatrists figure prominently in the mental health movement. Well, I think it follows inevitably even from the small section of supporting data I've been able to present today that mental health education has not had much impact on popular thinking. I think, too, the primary reason for the failure is readily apparent; it is that mental health education has primarily devoted itself to attempting to implant its psychiatrically-oriented conclusions into the thinking of people starting from quite different premises. Now these conclusions I keep referring to are generally called facts; you know, mental health education disseminates the facts about mental illness. Well, I've carefully avoided using that word fact, because I'm not sure there are any facts in the mental health field, aside from those which are sheer statistics, like how many people are in mental hospitals. So I prefer to talk about conclusions, without any reference to their absolute truth-value, but call them what you will--facts or conclusions--many of them don't make sense without their underlying premises and people are being far more logical in rejecting them than their proponents are being in circulating them.

Let me get concrete. There is, for instance, as far as I can see, no point to saying over and over again that mental illness is nothing to be afraid of to people who know very well that it is. What the statement means, if it means anything, is that the category of mental illness, as defined by mental health educators, contains many types of personalities or behaviors that aren't very frightening. True, but how can that influence a person who completely reserves the name of mental illness for those reactions which completely intimidate him? Well, all right, this then leads to an attempt to change conceptions of what is and isn't mental illness, and this is where education particularly creates dilemmas for the public. People are told that mental illness actually includes all sorts of things from the most grave to the most minor. And most people have a great respect for science and facts, so they try to go along with it. I didn't take the time to present that set of data, but we have some, establishing that most people are aware that they are "supposed to" look at mental illness that way. But it just won't work, it doesn't fit in anywhere, so it exists as an incongruity, a stray piece of irrelevant information, useful for quiz programs, perhaps, but not particularly related to anything real. So we find either that people sooner or later abandon any attempt to operate with psychiatric categories and go back to a usage which helps to organize everything into a consistent whole, or they hit upon a variety of awkward intellectual devices for attempting to straddle the two conflicting systems. Either way, it leads to a lot of shifting back and forth, and

a lot of inconsistency, confusion and illogical reasoning. Now all this is what we mean by the dilemmas of mental illness, but they arise, the confusion and inconsistency result, not from any inherent quality in popular thought, but from the well meaning efforts of adult-education.

Now to be fair I have to add that this isn't entirely news to mental health educators, and they have frequently seen that they'll have to go back to fundamental premises and attempted to do so. But most of the efforts of this kind that I've seen have made the fatal error of hitching the discussion of human behavior to mental illness, and showing that, after all, the emotional mechanisms of sick people aren't so different from you and me. Well, again, look at the premises into whose teeth this message is being thrown. These are people who conceive of mental illness as about as far from normal behavior as you can get; there's a gulf between them and the causal scheme applicable to normal behavior doesn't apply to mental illness at all. The threats inherent in this conception of mental illness are so great that they operate as circular reinforcement--the greater the gulf, the greater the fear; and the greater the fear, the greater the need to maintain the distance and separation. So this approach to fundamental premises couldn't have been better calculated to arouse resistance.

Since I'm a social researcher, I guess I could stop at this point, after this spirited demolition of the mental health education program and let it go at that. But it is intended to be applied research and I'm not really unsympathetic with the problems of the mental healthier, and, anyway, some of my best friends are mental health educators, so let me say something positive about approach, even though it sounds terribly obvious by now. It's just this, that maybe the time has come for mental health education to beat a strategic retreat from mental illness, to talk about normal behavior, about how people come to be the way they are and why they do the things they do, without all the impending doom and ominous overtones of mental illness lurking around the corner. Maybe after this much is accomplished, and I don't mean to suggest that even this much will be easy, the transition to mental illness will be less thorny.

Well, those are the most important practical implications of our research. I happen to think that we've come up with a formulation which is also a useful tool for clear thinking about such problems and often helps to illuminate if not eliminate the vital misunderstandings which muddy up discussions of psychiatry and mental health. If there's time, let me illustrate by one rather trivial, but amusing example. Take, for instance, a commonly-heard point in psychiatric circles, that in some ways psychiatry is overly-venerated, people seem to think psychiatrists are gods and can work miracles, and this is worrystome, and dangerous too.

Actually what the facts are is that people do quite casually assume that psychiatrists can easily remedy disorders which psychiatrists know from experience they can't, at least not easily and rapidly. That is, although we didn't actually code and tabulate the frequency with which people asserted that psychiatric therapy is a quick, easy, infallible process, we do know that roughly four-fifths of all references to the advisability of psychiatric care for one or another of the six examples people discussed came in contexts where the respondent was minimizing the gravity of the problem under consideration and, if you look at a random selection of verbatim comments, it's certainly a recurrent theme. For instance, here's a quite typical illustration. Describing what a psychiatrist does for a patient, a respondent says, "They try to talk to him, to find out what event or events caused it," so the interviewer asks what would he do then, and the respondent says, "Oh, the rest is simple; the tough part is finding out what caused it-- they have to go way back."

Or a few more quick ones: Speaking about the man we think of as a paranoid schizophrenic, a respondent says, "A couple of visits to a good psychiatrist who could find the cause of his hatreds and suspicions would clear it up." Or, speaking about the girl we regard as typifying a simple schizophrenic, one respondent says, "She just needs to be brought out of herself. A psychiatrist could probably make a normal person of her in a short time." Or, finally, to bring the facts out in the open, another respondent, referring to our example of an anxiety neurotic, says, "He could be helped easily. Either by a psychiatrist or by analyzing his own self or a friend might be able to make him see his faults."

Well, I think you see the point. These people are saying therapy is easy, quick, infallible, not because they think psychiatrists are supermen and miracle workers but because they fundamentally assume that changing people who are at all accessible to rational means of influence is so easy to begin with that anyone--even a psychiatrist--can do it. And, though these data may not seem very impressive, I do have many other data--particularly a whole set on the interchangeability of psychiatrists with self, family, friends, family doctors and ministers as equally satisfactory, equally competent and almost identical in procedure--which all add up only to the conclusion that psychiatrists don't do anything special and anyone can do it. It's just the different assumption about how easy it is to change behavior that makes the same attitude mean such different things to psychiatrists and to people.