What the Public Thinks about Mental Health and Mental Illness

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For the past two and a half years, the National Opinion Research Center has been engaged upon a pioneering study of the American public's thinking in the field of mental health, under the joint sponsorship of the National Association for Mental Health and the National Institute of Mental Health. It is a vast and ambitious project, and I'm afraid that the title which has been assigned to my remarks about the study is going to prove to be misleading in at least two ways.

In the first place, and this must be obvious, both the title given me and the scope of the study cover far more ground than I could possibly present in the course of one afternoon. About all I can do today is hit a few of the high spots in public thinking and emphasize beforehand that the study aims to be inclusive. You can pretty well assume that it contains some information on just about any question in the area you might raise, even though I don't refer to many of them. So, as they say in the more enterprising shops--"If you don't see what you want, ask for it."

In the second place, and this is more serious, I am in the embarrassing position of having to stand here this afternoon and honestly

admit that I don't know what the public thinks as yet. Like so many pioneering ventures, this research of ours has encountered such numerous vicissitudes along the way that I could consume the entire afternoon simply relating the heroic struggles to overcome epic obstacles that have impeded the study. With some self-restraint, however, I shall say no more about this phase of our project except that the study has not yet been completed. We now expect to have it finished by the end of 1953, and will begin, we hope, to have some definitive results by next Spring. Until then, however, about all we have to offer are some speculations, guesses and predictions about what public thinking will prove to be. As director of this research, I have had occasion to read and re-read over 2,000 of the 3,500 interviews which constitute our raw data and have found myself inescapably forced to think about their meaning and form some impressions of their general tenor. It is these impressions--what I think the public may think--that I shall be reporting today, in the hope that even such a preliminary report will prove useful. But, no matter how plausible I manage to make my opinions sound, you should always continue to remember that they are necessarily subjective, tentative, as yet unproved, and liable to radical revision in the light of the pending systematic analysis of the data.

With these disclaimers out of the way, let me start by saying that people's ideas about mental illness are ill-defined, confused, shifting and contradictory. When we start off our attempt to get people to talk about mental illness by asking, "When you hear someone say that a person is 'mentally-ill', what does that mean to you?", most people have great difficulty verbalizing at all about the concept. They can,

however, be led to talk in terms of the characteristics of the mentally-ill or the traits and behaviors by which such persons might be recognized, and, when they do so, they appear to be equating mental illness with psychosis, although, of course, most people would never use this term. But, generally, they speak of the mentally-ill as being "insane", "crazy", "nuts", "out of their minds", and attribute to them such characteristics as unpredictability, impulsiveness, loss of control, extreme irrationality, and legal incompetence; or such symptoms as hallucinations, delusions or violent behavior.

It is only rarely that people's initial reactions to the meaning of mental illness include any references to the area of neuroses or to emotional and personality disturbances, generally. This omission of the less extreme manifestations from the concept of mental illness can not be taken entirely at face value, however, for when we ask, very specifically, whether everyone who is mentally-ill is "insane" or "out of his mind", the majority answer is "No". The key term in the non-psychotic mental illness syndrome is "nervousness", and, in one way or another, people generally recognize the kind of disturbances of mood, of conceptions and self and of relations with others that characterize personality disorders.

At first sight then, it appears that a majority of the American public does distinguish, roughly, between "insanity", on the one hand, and "nervous conditions", on the other. If this conclusion were correct, public knowledge of the meaning of mental illness and application of this term to human behavior could be regarded as roughly approximating professional usage. The fact is, however, that, though people can be

pinned down to this more inclusive definition of mental illness by explicit questioning, they seldom stand by it. That is, whenever, people are encouraged to talk about mental illness, without being pressed for their definitions of the term, they tend to slip into a usage which corresponds to their original spontaneous identification of it with psychosis. Since people define the term in one way, but use it in another, inconsistency and illogic has to follow. Thus, for example, people will say that a "nervous breakdown" cannot be regarded as a mental illness, because a person can have a nervous breakdown without being "out of his mind", even though he has just said that there are other mental illnesses than "insanity." Or people, who, in defining mental illness, distinguished the non-psychotic forms as those which, in contrast to the psychoses, are temporary and easily recovered from, can also assert that a "nervous breakdown" or some other illustrative form of behavior cannot be regarded as mental illness because it is temporary and will be recovered from.

In a different way, a similar sort of paradox emerges when people are asked to apply their concepts of mental illness to a series of descriptions of six persons. With the help of psychiatrists, we developed descriptions of a paranoid, a simple schizophrenic, an anxiety neurotic, an alcoholic, a compulsive-phobic personality and an instance of childhood behavior disorder. To give you some idea of the quality of these descriptions, let me read one of them:

> Now I'd like to describe a certain kind of person and ask you a few questions about him...I'm thinking of a man--let's call him Frank Jones--who is very suspicious; he doesn't trust anybody, and he's sure that everybody is against him. Sometimes he thinks that people he sees on the street are talking about

> him and following him around. A couple of times now, he has beaten up men who didn't even know him, because he thought that they were plotting against him. The other night, he began to curse his wife terribly; then he hit her and threatened to kill her, because, he said, she was working against him, too, just like everyone else.

For each of the persons described, people were asked to indicate whether anything was wrong, what was wrong, what could have caused whatever was wrong, and whether the person should or should not be regarded as mentally ill. Well, when people stop talking in the abstract, and come down to individuals, in whom they can often perceive tendencies that they see in themselves and others, there is a remarkable inability--or unwillingness--to recognize mental illness. Of the six persons described, only the most extreme one --the paranoid--is diagnosed as mentally ill by anything like the majority of the public. Even when the person described corresponds rather closely with the images of mental illness that people have given us, the tendency is to reach out for new reasons why the hypothetical person should not be classified as mentally ill, rather than accept the implications of their original definitions of mental illness.

I could quote illustration after illustration to indicate this kind of shifting of ground, with consequent self-contradiction, but, if you will accept that it does exist, I think we can more profitably ask ourselves how such inconsistent thinking comes to be so pervasive. To answer this at all, we have to try, by inference, to tease out from what people say their underlying assumptions, premises and beliefs about the nature of mental illness and about human behavior generally, even though these are seldom made entirely explicit and are not always matters of awareness to the people who operate with them. While I do not have as yet exact enough data to indicate precisely how frequent any given line of thought is, it is possible to sketch

out some of the leading ideas and to indicate schematically the type of contradictions to which these lead. In no particular order these are:

1. It is a widespread notion that mental illness represents a continuum of inevitable development. It is not merely that some mental illnesses are more serious than others, or even that some mental illnesses may develop into more serious ones; rather, the idea is that all mental illnesses of whatever form are growing toward psychosis and will inevitably arrive at this stage unless something is done. The position is borrowed by analogy from a rather fallacious physiological doctrine--namely, "if you neglect a cold, it will turn into pneumonia." Since all mental illness is tending toward psychosis, it becomes relatively easy to confound the whole continuum with its end point, until, finally, only the end point is perceived.

2. The word "mental" in the phrase, "mental illness" cuts across several viewpoints which contribute to confusion. One of these, for instance, is the tendency to identify "the mental" with "the intellectual." It then becomes necessary to regard mental illness as disorders in which the purely cognitive functions must be impaired. This viewpoint is generally implicit in the thinking of people who tend to equate mental illness with psychosis. For them the essence of mental illness resides in qualities of irrationality, unreasoning behavior and the like, and so they say things like, "A lot of people who are nervous, their minds are as good as they ever was;" or "She knows what she is doing, so her mind can't be affected." This difficulty is more than a semantic one, since the people who use mental illness to mean disturbances of cognition do not generally mean to imply that some other term should be established to cover the other disorders that we would include under mental illness. Rather, the logic

seems to be, "If it isn't cognitive, it isn't mental; and, if it isn't mental, it isn't illness." One consequence of this viewpoint is a kind of belittling of any disturbance short of psychosis. Anything else can be viewed as an emotional or character difference of a non-problematic sort to be dismissed with some such statement as, "it takes all kinds of people to make a world." Or, probably the standard statement of this position is: "There's nothing mentally wrong--that's just a...," followed by almost any technical or non-technical term you can conceive of. It's "just a feeling the person gets" or "just emotional immaturity" or "just an inferiority complex," or "just a maladjustment."

3. The word, "mental", also has connotations which involve people in considerations deriving from a mind-body dualism. Psychosomatic approaches have not yet made much inroad or popular thinking, so that people are often involved in "either-or" reasoning and are asking themselves, "Is it physical illness or is it mental illness?" If they can perceive the causes of a given person's behavior as somehow physical, then this perception determines the diagnosis. Combined with the kind of behaviorism that is so prevalent and which may be described as having "lost its consciousness" this approach can subsume a great many things under "the physical." Thus, if a man is perceived as suspicious and distrustful because he is hard of hearing, that can be and frequently is called a physical reaction. The dilemma of this kind of behavioristic dualism is best illustrated by the way in which people deal with the nervous system. Some argue that the nervous system is a part of the physiology of the individual and therefore "nervousness," viewed as a malfunctioning of the nervous system, is classified as a physical illness. On the other hand, the nervous system

is viewed by others as including the brain, and to the thorough-going behaviorist "mind" is nothing but a loose term for brain, a position which would tend toward the conclusion that "nervousness" is a mental illness, if it were not for the fact that physiological or physical processes are so central. One fairly frequent solution to this problem elevates the nervous system to the status of a third order of reality--there is on the one hand "the physical" and, on the other, "the mental; but somewhere in between stands "the nervous", which is not quite physical but not quite mental either.

4. A related kind of dualism makes mental illness the residual, unexplained category in the explanatory system being applied to human behavior. Thus, to say a person is mentally-ill is, for many people, simply another way of saying that there is no way of accounting for the behavior of this person except by postulating mental illness. Mental illness, then, becomes a kind of causal explanation, which is not, itself, to be further explained and which is called upon to account to anything that would otherwise be inexplicable. Thus, people frequently say, "He'd have to be mentally-ill, because I can't think of anything else that would make him act like that;" or "If he weren't mentally ill, he wouldn't act like that."

When this viewpoint of mental illness as an unexplained residual category is combined, as it usually is, with the rawest kind of empiricism, --that is, the kind which assumes that its concepts and theories capture all of reality completely, mental illness becomes residual in still another sense. In this view, mental illness is what is left over when reality is subtracted. Now, reality to these behavioristic empiricists is always external to the individual's consciousness, if, indeed, he is permitted to have one. So, once again, any behavior whose causes can be traced to

reality, and that means primarily to the physical organism or to the environment that surrounds it, is not mental illness. The essence of mental illness, then, and this is a very widespread idea, is unreality; and actions, beliefs, emotions or what have you are mental illness only to the extent that they are uncaused by reality, "only mental," or "all in the mind."

5. If the word "mental" has its confusing connotations and associations, the word, "illness" is also not without its difficulties. Much of the discussion of mental illness goes on by means of hasty and not always correct analogizing with physical illness, so it should not be surprising that considerations of what is and is not illness are largely derived from this realm. Now, in essence, a physical illness may be regarded as something which is pathological for the organism, and, generally speaking, its presence or, at least, its onset is signaled by a change in the usual state of the organism--his temperature goes up, or his pulse falls, or he has an unaccustomed sensation, and so forth. Following this conception of illness, people find it difficult to view as mental illness, anything which may be regarded as a chronic manifestation of the personality--if a person has "always been this way," he is not mentally-ill, but if the same behavior is novel, not usual to the person, then it is mental illness. People, thus, are often looking for acute and dramatic manifestations--sudden collapses, psychotic breaks, and any kind of equilibrium appears nonproblematic as long as it is maintained.

On the other hand, there is another way of viewing physical illness in which the condition is defined as pathological because it is not the usual condition of the species, however customary it may be in the individual organism--here, by way of illustration, you might think of the glandular

or metabolic disturbances; for instance, a person with a BMR of -40 is viewed as problematic, even if his BMR has always been at this level. Now, these two views of illness are easily merged in physical illnesses, because most frequently, what is not usual to the species is not usual to a single member of that species either, but they lead to different outcomes when applied to mental illness. According to the "species" view of illness, and with a liberal reinforcement from doctrines of cultural relativism, whatever behavior is widespread among people, common to many of them, cannot be viewed as illness. Thus, there are many people to whom the "neurotic personality of our time" cannot be mentally-ill, just because he is the average man.

6. Another one of these general, half-formulated premises which enter into the discussion of mental illness, we cannot overlook the fact that considerations of moral responsibility are always being imported, generally in the form of assumptions about self-determinism or free will. In its simplest form, it can be seen in the tendency of many people to regard loss of self-control as the essence of mental illness. More typically, however, the loss of self-control is combined with mind-body dualism into the view that self-control or "will power" is a function assignable to "the" mental rather than "the" physical, so that any impairment or weakness in self-control is by definition mental weakness or illness. More important, however, the doctrine that individuals are, could be or should be accountable for their own actions automatically makes of mental illness a term used to blame or excuse individuals for their shortcomings. There are, for example, many people who refuse to define as illness any manifestations which they regard as within the control of the individual;

for them, emotional symptoms become primarily evidence of character weakness and moral defect, as for example, the people who say things like "It isn't mental illness because he could snap out of it if he wanted to." Other people do call such evidences of weakness and moral culpability mental illness, but only because mental illness has become an epithet used to stigmatize such tendencies. Thus there are people who feel that certain behavior patterns are mental illnesses because they are within the control of the individual, and there are others, even more critical of the presumed personal weakness expressed in the behavior, who refuse to extend the sheltering term of illness to defects of character. When essentially moral views of this order get combined with other considerations like the reality of the causes or the nature of illness as a deviation from normalcy, a very common position emerges in which aberrant behavior can be viewed as chronic manifestations of personality, so ingrained in the individual as to be beyond his control. Thus, if the behavior can be viewed as a function of heredity, temperament, or basic character structure which goes too deep to change it, it is not to be considered as mental illness. People who think in these terms often make it very clear that sporting considerations of fair play are entering into their decisions; that is, mental illness is a term of reprobation which should not be assigned to individuals for matters which are not actually their fault. For instance, one person said of the paranoid man, "I wouldn't say he was mentally-ill; maybe the poor fellow can't help it because it was born in him." Quite similarly, the emotionally disturbed child is often held not to be mentally-ill, because the ultimate responsibility for his behavior is attributable to his parents.

7. Finally, I think it is quite important to note more explicitly that the prevailing mode of accounting for human behavior employs a scheme which is highly behavioristic--mechanical, rationalistic and naively empirical. Primarily, people seek for direct, concrete, immediately-perceivable connections in experience between the behavior and its causes. Thus the frequent tendency is to think in terms of causes which correspond closely, in common sense experience, with the symptoms or the behavior to be explained, with little or no awareness of or attention to either symbolism or irrational factors in behavior. Perhaps a few illustrations will make more clear what I mean here: Take, for instance, the paranoid who was described as suspicious and distrustful, and acting quite hostilely toward people--The most usual way of accounting for such a person is to assume that at some time in his life he has genuinely been the victim of persecution, injustice or mistreatment; which justified him in feeling, at least at that time, that people actually were against him. From this kind of conditioning, he has generalized or overgeneralized to all people. Or the schizophrenic girl, who is described as withdrawn and apathetic, is almost always perceived as not conditioned to sociability. Either her parents did not teach her to like people, failed to "push" this rather backward child into social activities to counteract her withdrawing tendency, or for one reason or another, severely limited her social contacts; or else it must be that something about her--her appearance, talents or personality--led to rejections and rebuffs in social relations, which taught her to avoid them. Or, take the girl who is described as compulsively checking her gas and door and phobically avoiding elevators: Almost always, her behavior can only

be explained by referring to experiences which involved these elements--she has learned this behavior from experiences in fires, thefts, elevator accidents. Out of all the interviews I have examined, there were three which explicitly stated that probably her behavior had nothing whatsoever to do with the usual social meaning of doors, gas or elevators.

In a way, the essence of such explanations of human behavior is their superficial reasonableness: They check against the way people have experienced life and their external observations of others. When carried into the realm of thinking about mental illness, however, they have logical difficulties. If on the one hand, behavior, if it is to be explained at all, has to be regarded as a reasonable response to certain life experiences, how, on the other hand, can it simultaneously be regarded as mental illness, when the essence of mental illness is, for so many of these same people, "unreasonableness" - inexplicableness, irrationality, unpredictability, or, in general, failure to conform to the "reasonable" cause-effect scheme? Well, this dilemma can be and is solved, but only by the use of one of the assumptions which have been discussed. The rigorously logical, who adhere to the notion of mental illness as the residual category which cannot be explained, simply deny that anything for which they can adduce such a reasonable explanation is mental illness. Others reintroduce notions of free will and personal responsibility and establish the behavior as mental illness because the individual has allowed himself to carry his reasonable reaction to unreasonable lengths. In either case, the emphasis still remains on control and rationality in human behavior.

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Well, I think you can see, even from this hasty review of them, how any one of these more prevalent underlying assumptions might easily contribute to confusion, especially when they are not explicit, theoretical positions all of whose implications are accepted, but are unexamined first principles. To add to the confusion, however, I think we will be able to show, when the study is completed, that almost everyone's thinking about mental illness implicitly has entangled in it elements derived from each of these modes of thinking. By way of honest confession, I have recently been listening critically to my own casual conversations and those of my friends, and I can perceive in myself and in them unthinking traces of each of these modes of thought, even though we would probably disavow almost all of them when we are being self-consciously intellectual. I think you can observe this even in the writings of many psychiatrists. But, whatever you may think of the merits of any one of these ways of thinking about mental illness, taken separately, nothing but an utter hodge-podge can emerge when these mutually-exclusive assumptions are incorporated into the outlook of a single person. Starting with almost any facts, one can, with a selection from these premises, arrive at almost any conclusion, or arrive at different conclusions at different times, or, even, arrive at different conclusions at the same time.

I see I have spent most of my time on this initial topic of conceptions of mental illness, but I do think that it will serve to illuminate any other topic. Still, I would like to touch, at least briefly, on three other aspects of the subject: views on treatment and prognosis, attitudes toward the mentally-ill, and attitudes toward the profession of psychiatry.

First, then, treatment and prognosis. Ideas about the treatment and

prevention of mental illness necessarily reflect the basic viewpoints about its essential causes, and , since the public generally has little specific knowledge of techniques, usually do little but indicate, once again, underlying assumptions about mental illness.

By and large, a favorable prognosis was generally assigned to the neuroses. Most people felt that a person could recover from a neurosis, and many people felt that recovery was simply a matter of measures which any person could take for himself. The lines along which "self-help" might proceed were essentially of two general kinds, the first involving direct psychological transformation of the person by himself; the second, his use of such psychological strengths to shape the physical conditions of his existence. Belonging in the first group was such advice as: "They have to use will-power;" "You have to make yourself stop worrying;" "If he tries hard enough, he can change himself;" "Just make up your mind to snap out of it;" "Start concentrating on others more than on yourself." The second viewpoint recommended that the individual slow down the tempo of his life, take care of his physical condition, and follow a sensible regimen which might include such measures as giving up undesirable practices like smoking or drinking and avoiding overwork. This "rest and relaxation" view was frequently accompanied by the idea of getting away from things temporarily--taking a vacation or changing one's activities, either for the sheer physical rest involved or for the perspective on problems which might be derived.

There were, on the other hand, many people who felt that the individual's efforts to help himself needed reinforcement by the assistance of others, and others who felt that only outside help could be effective in

the treatment of neurosis. The sources of outside help most frequently mentioned in this connection were family doctors and other medical practitioners, psychiatrists, religious advisors, and one's own family and friends. In a rather large number of cases, there was little division of labor made among these various sources of help. They were frequently mentioned as alternative sources, any one of which might do the same thing for the afflicted person, and only rarely or in the most obvious connections were these groups perceived as having destinctive functions. Thus, spiritual assistance was pretty much a function limited to religious advisors, and the treatment of physical illnesses which might be regarded as reinforcing or causing the emotional disturbance was primarily delegated to medical practitioners, but all these sources of help appeardd as equally competent to offer psychological assistance and practical advice of one sort or another.

Characteristically enough, people who called upon outside help in the treatment of neuroses saw the helpers as doing for the patient much the same sort of thing as the patient was regarded by the other school of thought as capable of doing for himself. Thus, their activities were primarily described as, first, assisting the person to transform himself through the highly rational psychological means of explaining to him what was wrong with him and reasoning with him to persuade him to change his thinking or to "talk him out" of the peculiar notions he might have. Second, they offered advice or saw that their advice was acted upon with regard to such matters as how the afflicted person might organize his life and the proper activities for him to engage in. Fiaally, they prescribed or saw to it that the person got the proper rest and relaxation.

In contrast to the neuroses, the prognosis for psychoses was a good deal less optimistic, There were, of course, some people who were simply indicating their knowledge of the existence of some psychoses, like those with organic involvements, which are intrinsically incurable. Many more people, however, were convinced that all psychoses are intrinsically incurable, although a large number of them could do little more than reiterate this belief in explanation, as, for example, people who said that psychotics could not be helped to recover because "they just never become better again"; "it's hopeless"; "it isn't curable"; etc. Part of this pessimism derived from some tendency to think of mental illness as a continuum, along which psychosis is viewed as the irreversible end stage, so that treatment is only possible before the mental illness reaches the point of psychosis. Others believed that all psychoses had a hereditary base which treatment could not modify, or that all psychoses necessarily involved uncorrectible brain (or "mental") damage.

In addition to these people who believed that treatment of psychoses is impossible in view of the intrinsic nature of the illness, there were a good many who believed that there was, in practice, little or no chance of recovery from psychosis. These people implied that there was nothing in the nature of the illness that stood in the way of recovery, but that practical difficulties in treatment existed. They were thinking of such factors as a lack of facilities for treatment, low standards in existing facilities, incomplete scientific investigation and understanding of mental illness, lack of detection of cases in need of treatment, concealment, and a general atmosphere of "too little and too late."

Ideas about the treatment of psychoses were, however, a good deal

vaguer than the suggestions people had to offer for the cure of neuroses. For many people, what could be done to cure a psychotic was summed up in the one word, "Treatment", and there was some feeling that this was, after all, a highly specialized matter best delegated to mental hospitals and their personnel. Where people did claim some knowledge of what was included under the heading of treatment, their views stressed physical care of the patient, including rest, quiet and temporary change of environment, the provision of distracting or constructive activities to occupy the patient, and the newer physical therapies--primarily shock treatment and psycho-surgery.

Discussion of the prevention of either neuroses or psychoses corresponds, to a remarkable extent, with the discussion of treatment of neuroses. Insofar as preventive action is conceived as possible, the same sorts of help are called upon and the same sorts of measures are contemplated. Prevention is, thus, viewed as largely a matter of steps to be taken--by the individual, himself, his family and friends, medical practitioners, or the psychiatric profession--to ensure the person's physical well-being, to alleviate any environmental stresses that may be present, and to accomplish, by rational means, the kind of psychological transformation necessary to strengthen the individual's ability to use his will power and self-control in the management of his emotions. Only in the exceptional instance is anything said about beginning prevention through the kind of upbringing children experience, and, when it is, it tends also to assume a rationalistic and moralistic tone. In those few instances, the dominant themes are that parents must inculcate moral standards or develop character in their children, or that they must teach their

children to be emotionally mature and realistic in their approach to life. Similarly rare is the view that preventive action requires social change--that individuals cannot develop into emotionally stable persons unless their society provides them with a milieu of stability and security through the elimination of war and threats of war, the provision of economic security, and the mediation of conflicts in cultural values. These views of prevention could have been predicted, since preventive actions can only be directed toward what are perceived as the causes of mental illness.

There is, however, a rather widespread conviction that nothing can be done to prevent mental illness. In some views, the presumed causes of mental illness, whether heredity, injury to the brain, temperament, or the everyday experiences of life, are viewed as unpreventable. In others, a general philosophy of fatalism prevails (e.g. "What is to be, will be"; "If his mind is going to crack, it's going to, don't make no difference what you do".) More often, however, the view is that there is no way of knowing or doing anything about something which has not yet happened, so, by the time there is any reason to take action, the action must take the form of treatment rather than prevention. This way of thinking is, of course, putting a high premium on perceptibility: if symptoms are perceptible, illness is already there; and if nothing is perceptible, then there is no reasons to assume any problem. Especially with respect to the psychoses, this opinion is carried to the logical conclusion of regarding the onset of mental illness as a sudden thing, since nothing is noticed until an acute break occurs; these are the people who believe that "suddenly something snaps"; "it could happen overnight:; and so forth. In general, these people are thinking in terms of absolutes of "illness--not illness", in terms of discrete, immediate causes, and in terms of extreme,

externally-perceivable symptoms; hence, the whole question of prevention appears to them silly and stupid, as, for example, in the case of a woman who patiently explained, "It's all the same--you have no way of knowing that someone is going to break a leg until he does, so how could you do anything about that!" And over and over again, people said, "You wouldn't know anything until they are that way"; "There's no way to know beforehand"; and so forth.

The contrast in views of prognosis and therapy as between neuroses and psychoses, which has just been presented, carries with it a number of implications about the attitudes which people have toward mental illness and the evaluation which they make of the mentally-ill. There is, in the first place, a tendency to underestimate the seriousness and deepseated nature of emotional disorders short of psychosis. While the tendency was apparent in the earlier discussion of the conception which regards non-psychotic mental illness as transient, it receives further confirmation from views which regard the treatment of neuroses as a simple, unspecialized operation which the individual may carry on for himself or which may equally well be done for him by people with a wide variety of special skills. Secondly, however, the tendency is to make of neuroses a moral problem as opposed to psychoses, which are perceived as medical or psychiatric problems, almost always involving the special skills of doctors and hospitals. The emphasis on self-help, on the one hand, as the solution to emotional problems, and, on the other, the implicit assumption underlying most other forms of help that the neurotic individual is able to profit from rational advice bring doctrines of free will and personal responsibility to the

forefront. The net effect of this kind of thinking is to make of the illness, implicitly or explicitly, something for which the individual is responsible and is subject to condemnation, and to place on the individual the ultimate responsibility for his recovery, as well. These moral views of emotional problems tend to minimize their seriousness and go along with little interest in, understanding of, or concern for neurotic disorders.

Finally, however, these contrasting views of neurosis and psychosis suggest that the tendency is, if anything, to exaggerate the seriousness of psychosis and, while so doing, to deny the competence of the layman to understand or concern himself with its treatment. Attitudes like these cannot be fully understood apart from the nexus of superstition, taboo, fear, dread and avoidance in which they are embedded. It is almost enough to reiterate that many people view psychosis as a serious illness whose causes are not fully understood, whose occurrence can not be anticipated or prevented, and whose onset may without warning be initiated by some everyday experience that no one can avoid. These views alone would make intelligible the great fear that so many people have, espccially when reinforced as they often are, by a belief that recovery from psychosis is impossible or at least infrequent and that those who do recover never do so completely, but always "show some signs" of their former illness. The fear and avoidance surrounding the topic of mental illness can, however, be documented in many additional ways.

As one line of evidence, there is the fact that nowhere in the entire sphere of thinking about mental illness is there so much agreement as on the question of whether or not psychotics should be hospitalized.

Almost everyone believes that they should be, and this opinion has little to do with views on either the curability of psychoses or the adequacy of mental hospital facilities and standards for this task. The one most cogent argument in favor of hospitalizing psychotics is the widely held belief that all psychotics are a source of physical danger to others--or, at least that there is no way of telling whether they are dangerous or not--so that, for the protection of society, these people must be confined to institutions. This position is, of course, one which defines the institution's function as custodial. It is not too surprising, therefore, that the next most frequent reason advanced in favor of hospitalization is an emphasis on the need of the psychotic patient for care, with no implication that care is intended to contribute to the patient's recovery. Rather, the idea appears to be that these institutions are more specialized, their staffs know more about coping with the patient than any lay person could, and they relieve the family of an unwanted burden and responsibility. This whole line of reasoning, the tenor of which is to extrude the mentally-ill from society, if not from consciousness, is sometimes bolstered by an apparently therapeutic consideration that the home environment would not be good for a psychotic patient anyway, or he would not have become ill. It cannot be lost sight of that there are some people who clearly and unambiguously believe that hospitalization is at present the necessary condition for effective therapy, just as there are a few people who, from considerations of therapy, are completely opposed to hospitalization, but the dominant tendency is, as indicated, to resolve the question of hospitalization in terms of the fears and needs of the non-psychotic.

The "dangerousness" of psychotics for other people is not merely a problem of the tendencies toward physical violence which many people attribute to psychotics, even though it is often put in these terms. Running through what people say, however, are expressions of the kind of anxiety generated in people when they are forced to deal with persons whose behavior is not to be understood or controlled by the means which are applied in everyday interpersonal relationships. Over and over again, the element of "danger" is described in terms of the psychotic person's being unpredictable, irrational, and not responsible for his acts. He is dangerous just because "you never know what they are going to do" or "They might do anything," and the very uncertainty constitutes the real threat. In fact, a frequent, though less common point of view, sees a danger of emotional damage to people required to associate with the mentally ill, just because of the constant strain, tension and anxiety which such contacts are assumed inevitably to create.

The fears and anxieties which pervade people's thinking about the psychoses extend, as well, into their attitudes toward patients who have recovered. Even when this topic was introduced in a favorable context--that is, when respondents were asked to assume that they had first become acquainted with the person without noting anything abnormal about him and had only then learned that he had once been psychotic--the most frequent reaction was fear, distrust, suspicion and apprehension, deriving primarily from the assumption that the person could not be really cured or that recurrences and relapses were to be expected. Out of this underlying reaction, about three main orientations emerge: The most frequent approach to former patients is one characterized by a combination of oversolicitude and appeasement. People following this approach would be, on

the one hand, sympathetic, pitying, indulgent and kind, and, on the other hand, would be studiously avoiding anything which, in their view, might disturb or provoke the ex-patient. They would, for instance, be very careful never to remind him that he had once been mentally-ill, never to use terms that he might take as insults--"That's nuts," "You're crazy," and the like--and always to be on their guard to avoid any arguments, disagreements or any other acts which might constitute provocation. The whole position is characterized by handling the former patient as if he were a crate of highly fragile or highly explosive material, or, as one respondent summed it up, "I would try to handle them with kid gloves." It is to be noted that many of the people who subscribe to this approach assert that this would in no way constitute a departure from their previous feelings about and attitudes toward the person.

The second approach to former patients carries the fears and apprehensions one step further to the point of either avoiding recovered patients entirely or of limiting contacts with them to various public, casual situations and avoiding more intimate, continuing contacts.

The third approach is one which explicitly acknowledges that knowledge of previous mental illness would make them uncomfortable and unnatural.

The general tendency is to assume that whatever else may be said about one's own reactions to former mental patients, they are at least favorable as, and probably more favorable than, those of the average person, for it is simply taken for granted that other people would endorse one's views or carry them even further in the directions just outlined. Thus, a variety of beliefs and superstitions, which make of mental illness a topic which people prefer not to think about and to avoid as they can,

lead also to attitudes toward the mentally-ill that constitute a real hindrance to the readjustment of recovered patients in normal society.

Finally, let me steal a few more moments to say a word about the public status psychiatry. Psychiatry occupies a peculiar position in that it is apparently more accepted than it is familiar and certainly more familiar than it is understood. Very little is known about psychiatry, except the fact that it exists, and often even this fact is arrived at as a logical deduction from a knowledge of medicine; or, as one person put it, "They have specialists for everything else so there must be a doctor for nerves, too." And the public's approach, by and large, stays at this factual level; there is very little enthusiasm for psychiatry, but very little open hostility as well.

The fact is that people are, for the most part, content with their own "commonsensical", "reasonable" approach to human behavior. It works well enough for their everyday problems and they have little awareness of the logical inconsistency in their thoughtways or of any need to understand themselves and others more fully than they do. But, the outcome of the public emphasis on rationality, on externals in behavior and on free-will and self-determinism, is a view in which psychiatrists are, implicitly at least, denied any specialization--what they do for a person with a problem is in no way different from what anyone with the time and interest might do for a person with a problem, aside perhaps from such technical trimmings as couches. The prevailing doctrine is that "everyone understands people" and would, insofar as they have correct understanding, proceed in the same way in dealing with them. In the absence of information to the contrary, it is, in fact, assumed that psychiatry

operates with the same interpretive schemes of human behavior as have popular currency. The widespread existence of this assumption, together with the lack of felt need to understand more and consequent ignorance about psychiatry, ensures that the basic conflicts between psychiatric and popular theories of human behavior are not matters of public awareness. The challenge to popular expertness that psychiatric theories might pose and the ensuing disagreement and hostility that would result are, thus, minimized. At the same time, however, psychiatry is left with little claim to expert knowledge and, therefore, with little claim to public respect.