

THE PUBLIC'S IDEAS ABOUT MENTAL ILLNESS

A Paper Presented by
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(As our chairman has rather more tactfully suggested, I have become the somewhat perennial representative of a unique study.) By way of background, let me say that this research is a pioneering attempt by the National Opinion Research Center, University of Chicago, to subject to thorough analysis the nature of popular thinking about mental illness. The study is based on thirty-five hundred intensive interviews--interviews of about an hour and a half's duration--with a representative cross-section of the American public and is, so far as we know, the only such study attempted on a national scale. The goals of the research are, first, to describe in some detail the characteristic ideas about mental illness current in our society and, second, to explain--so far as we can--the reasons why popular conceptions of mental illness assume the form they do. Because of their firm conviction that understanding of this order is needed for effective information programming, the research is cosponsored by the National Association for Mental Health and the National Institute of Mental Health. It has had the benefit of help and advice from both of these groups and from a large number of psychiatrists including both the GAP and the APA Committees on Public Information. And, finally, I should add, the study has had the generous and patient financial support of a number of foundations.

So much for background. I am still faced with the embarrassing task of mentioning, however, that the study has been in progress for some five years now. We have discovered an almost inexhaustible amount of information in the study and have not yet been able to bring ourselves to stop exploring and publish what we have; though we currently swear we will by early next year. I mention this for two reasons over and above the guilt we feel about the long delay: first, because I will today talk about only the smallest fraction of our results, and, second, I'm not at all sure that the aspects I've singled out will actually be those that interest you most. In either case, I hope that in the discussion period you will not feel limited to the content of my remarks, but will raise any and all questions that occur to you.

So, to get down to the data, let me start with the materials which bear most directly on the present outlook for an intensified attack on the problems presented by hospitalized mental illness, for, this, I assume, is one of the most immediate and pressing problems concerning this Association. In the first place, 71 per cent of the American public feel that a person who "goes out of his mind" can generally get better again. (An additional nine per cent think some can, but aren't sure about the majority; 11 per cent think the average case cannot get better again; nine per cent have no opinion.) Even more decidedly, 91 per cent believe recovery from "nervous conditions" short of psychosis is generally possible. (Another five per cent think it is at least sometimes possible; two per cent feel recovery is generally not possible, and two per cent just don't know.) Moreover, in talking about recovery from mental illness, 56 per cent recommend either a mental hospital or a psychiatrist (MH-45)--though not always in exactly those terms, of course--for the treatment of psychosis. Similarly, 52 per cent recommend professional psychiatric

treatment for "nervous conditions" (MH-5). When people are asked what they would do if someone in their family started acting peculiarly--or, as we put it, "was not acting like himself," 63 per cent say they would turn to psychiatric facilities (MH-9)--sometimes, immediately (18); more often, after the help obtainable from family, friends or general practitioners proves ineffective (45). If we put all these differing questions together, at one time or another 85 per cent of the American people gave this kind of positive support to psychiatric treatment (MH only=12). And, when we shifted from asking people about the treatment of mental illness to asking them to characterize the kind and severity of problem that a person should have before consulting a psychiatrist, the same general impression emerges: by far the largest group in the population--46 per cent--feels that treatment should be sought without delay, before problems have a chance to become serious, at the first occurrence of symptoms. (Next highest="due course"=18.)

So, on the basis of facts like these I think it is fair to say that the average American adult knows that mental illness can be treated and knows that its treatment involves special facilities--psychiatrists and institutions. I think too, it can be said that the average American either knows that present facilities are not entirely adequate or will accept the accuracy of that statement if it is authoritatively presented to him. Certainly the bulk of the public knows or believes that the majority of psychotic patients do not, in fact, recover, regardless of the theoretical possibilities. If we take only the 71 per cent who believe that a psychotic generally can get better again, they divide into 32 per cent who feel that in practice most do not get well, nine per cent who say about half get well, 20 per cent who say most do, in fact, recover and 10 per cent who have no impression of what recovery rates are like. In other words only a fifth of the American population believes that most psychotics can and do get better again, while two-fifths feel that most can, but don't. For this latter group, the story is largely a matter of "too little and too late." There is a general feeling that, for whatever reasons, patients do not reach treatment soon enough and that, once they do, present knowledge and facilities are inadequate to the task of treatment.

Since we were working on a national scale, we could not know the exact facilities available to each person we talked to, and, consequently, did not ask any direct questions about them, but, even so, roughly one person in every five volunteered to us comments about the shortage of psychiatrists or the need for more research or the inadequacy or insufficiency of hospitals in their areas. And when we told people something about the size of the problem of mental illness in the United States--I think we said that "one out of every ten people in the United States will have some kind of mental illness or nervous condition in the course of their lives" and that "over half the hospital beds in the country are occupied by people who are mentally ill"--and asked them what should be done about a problem of this size, over half (52%) the people who weren't simply stunned by the enormity of the problem (13) or resigned to the status quo (5) answered in terms of improving facilities (T=43+10). The main things they said were: "More hospitals"; "More-adequately staffed hospitals"; "More psychiatric clinics" or some form of less-expensive psychiatry; "Increased research to learn more about the causes and treatment of mental illness" and "Increased subsidies or whatnot to expand the number of psychiatrists available." And all of the many studies that have been done in separate localities--a particular city or a state and so on--pretty well support this picture. To cite just one, a recent survey of the adult population of New Jersey--a study, incidentally, financed by that state, to its everlasting credit--found 63 per cent agreeing with the statement that "There are not enough doctors or hospitals in New Jersey to give proper care and treatment to all the people in this state who are mentally ill today."

Now I certainly don't want to dismiss findings like these. Quite the contrary, I started with them just because they are important. They tell us that on one very vital mental health front--the task of mobilizing community facilities for the more effective treatment of mental illness--there is already a good measure of public acceptance which can probably be still further increased. I don't say it is whole-hearted; I don't say it is enthusiastic, but I don't see how we can deny that the majority of the public now recognizes the need for treatment facilities and will, however reluctantly, go along with expanded public programs in this area.

But, it seems to me that the mental health movement aims at accomplishing a good deal more than simply managing to do better what we now do in any case--to increase facilities at a rate sufficient to cope with the ever-increasing case-load or even to increase substantially the percentage of recoveries among hospitalized cases. And, when it comes to these more ambitious and long-run goals, the doing of things that are not routinely done now--say, as a minimum, earlier case-finding and detection, earlier referral and earlier treatment or, as a maximum, actual prevention of mental illness and positive promotion of mental health--the data I've cited are not only irrelevant, but they are most likely misleading. There is, as I'm sure you all know, a famous old recipe for rabbit stew which begins, "First, catch your rabbit." Now the catch, when people say that a person with a mental illness needs professional psychiatric care and that, ideally, treatment should be sought as soon as the first symptoms occur, is much the same thing: they know something of how to cook a rabbit, if they ever encounter one, but they are not prepared to recognize one if it bit them, much less to catch one.

I'm talking pretty loosely for a sober research report on a serious problem, but this does bring me to the heart of our study. For, even though I've just given you some results bearing on the question of whether people know what to do once they know that they have a case of mental illness to contend with, our primary focus of interest has been on that logically-prior question represented by the qualification, "once they know they have a case of mental illness to deal with." In other words, we have been concerned with how people define for themselves what mental illness is, how it differs from other forms of human behavior, how it develops and how it is to be recognized when it occurs. This is an area where we are dealing less with what facts people know than what beliefs they adhere to, and it is here, in my judgment, that mental health education as distinct, perhaps, from mental health action encounters its thorniest problems.

So let me review for you briefly the main results of this part of our study and the problems they highlight. Actually, each interview began by asking the person to describe for us what he meant by mental illness. We asked, "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, but, with the help of additional questions like, "What is a mentally-ill person like?" or "How does a mentally-ill person act?" or "What does a person do that tells you that he is mentally-ill?", almost everyone can, ultimately, be led to talk in terms of characteristics of the mentally-ill or the traits and behaviors by which such persons might be recognized. From their descriptions, it appears that just about half the public equates 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 violent behavior, incomprehensible talk, delusions or hallucinations.

For slightly less than half the public, initial reactions to the meaning of mental illness include reference to the area of neuroses or to emotional and personality disturbances, generally. But the omission of less extreme manifestations from the concept of mental illness by the larger segment of the public cannot 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 this nonpsychotic mental illness syndrome is "nervousness," and, in one way or another, about two-thirds of the public recognize the kind of disturbances of mood, of conceptions of 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. 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 in addition to "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 or 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 talk 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 ability--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. The exact figures here may interest you. They are:

Paranoid	75%
Simple schizophrenic	34
Alcoholic	29
Anxiety neurotic	18
Disturbed child	14
Compulsive-phobic	7

Even when the person we described corresponded rather closely with the images of mental illness that people had given us, the tendency was for these same people to reach out for new reasons why that hypothetical person should not be classified as mentally-ill, rather than to accept the implications of their original definitions. For instance, we described the anxiety neurotic as "nervous"--tense, anxious, irritable and insecure, and this was, of course, the exact characterization of a non-psychotic mental illness which many people had previously given us. Well, when we take only the people who described this kind of anxiety syndrome as mental illness, we still find only 20 per cent of them saying that our particular instance of anxiety neurosis is mentally ill (vs. 15).

In effect, then, we have a situation in which people generally started by saying that there are all kinds and degrees of mental illness and ended by denying or failing to recognize that anything short of the most extreme manifestations is a mental illness. When we look at our data for an explanation of why this should be (and let me say, parenthetically, that we firmly believe that it is not to be explained as human capriciousness, mass stupidity or any such dismissing epithet), we find that there are a number of principles people rely on in trying to decide whether or not a particular person's behavior represents mental illness. Their discussion at this point centers around the nature of rationality, self-control and normalcy, generally, with some side excursions into such questions as the difference between the physical and the mental. Since time is short, I will hew to the main line in this presentation.

In practice, people make it clear that they do not generally regard behavior as proof of mental illness, unless three interrelated conditions obtain. First of all, they look for a breakdown of intellect, an almost complete loss of cognitive functioning or, in short, a loss of reason. And so, in explaining why a particular example is not mentally ill, they frequently 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." Second, people expect, almost as a necessary consequence of this loss of rationality, that the behavior called mental illness must represent a serious loss of self-control, usually to the point of dangerous violence against others and certainly to the point of not being responsible for one's acts. Here people say an example is mentally-ill because "He isn't in control of himself" or because "He's getting dangerous for the people who live with him," or someone else is not mentally-ill because "He isn't doing things he shouldn't be doing" or because "He isn't really out of control--he could stop acting that way if he wanted to."

Finally, people feel that, to qualify as mental illness, behavior should be inappropriate--that is, neither reasonable nor expected under the particular circumstances in which the person finds himself. What this amounts to is that as long as a person's behavior can be viewed as logical, motivated or determined, people feel they can understand it, especially if it is an expected, predictable way of behaving in a particular situation. And this is so largely the dominant view of

the roots of human behavior, that people tend to assume, look for and find rational, understandable causes of even extremely deviant behavior. Perhaps a few examples will help to clarify what I mean. Take, for instance, the paranoid whom we described as suspicious, distrustful and acting quite hostilely and violently toward others: the most frequent way of accounting for such a person is to assume that at some time in his life he has genuinely been a victim of injustice, persecution or mistreatment to which his reaction was, at that time, at least, a logical, understandable response. 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.

The significant thing about all these explanations, as well as other kinds which attribute problematic behavior to willful misconduct or to physical illness, is that they represent people's usual attempts to make the behavior of others intelligible to themselves. And, as long as the behavior can be made intelligible, the tendency is not to regard it as mental illness. So, people frequently say things like, "He must be mentally-ill, because I can't think of anything else that would make him act like that" or "It doesn't have to be mental illness--it might just be his parents didn't raise him right."

Now, all of this, I am sure, has a most familiar sound to all of you, and not just because I have been giving this kind of talk for several years now. It is, of course, about the same set of moral norms and premises about man and his nature that underlies all of our legal codes, governing who shall be held responsible and punished for his acts and who shall be exempt from punishment by reason of insanity. Or, in other words, it is an expression of an internally-consistent, rather well-organized, morally-grounded view of human nature and of human conduct that is deeply engrained in Western civilization.

According to this view of man, rationality and the ability to exercise self-control are the central, basically human qualities. From this, it follows that the normal person is rational, he is able to control himself and is responsible for his acts, and his acts are reasonable--appropriate to the circumstances in which he finds himself and intelligible to others in the light of those circumstances. Given this view of normalcy, it follows quite consistently that if mental illness represents the loss of normalcy or its opposite, it must necessarily turn out to be a rather extreme form of psychosis.

Given this orientation, it also follows that mental illness is a very threatening, fearful thing and not an idea to be entertained lightly about anyone. Emotionally, it represents to people loss of what they consider to be the distinctively human qualities of rationality and free will, and there is a kind of horror in dehumanization. As both our data and other studies make clear, mental illness is something that people want to keep as far from themselves as possible. I would particularly call your attention to a study being done under the direction of Dr. John A. Clausen of NIMH which, as one of its phases, examines the process by which the wives of hospitalized mental patients actually came to define their husbands as mentally ill. Much more than our stories about hypothetical people can, his results

underscore the extreme reluctance to conclude that the husband's behavior must signify mental illness, the many alternative explanations which these wives clung to as long as they were at all tenable, and the way this denial can, in extreme instances, persist even throughout the period of hospitalization.

As for our data, the very fact that so many people recognize the need for professional facilities to care for psychotics--a fact which I cited earlier in a more positive context--is at the same time an expression of this desire to disassociate themselves from mental illness. That is to say, the typical psychotic patient is viewed as dangerous by more than two-thirds (69+6?) of the American public and, more for this reason than for considerations of treatment, about the same proportion feel that all psychotics should be institutionalized. The interesting thing is that when people make clear what it is they mean when they say psychotics are dangerous, it turns out that they are not primarily or exclusively thinking in terms of physical violence. Running through what people say, there are, more frequently, expressions of the kind of anxiety generated in people when they are forced to deal with persons who have lost their crucially human qualities, persons whose behavior can neither be understood or controlled by the means which are applied in every-day 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, not so much because of his overt acts, but because--to quote some typical responses--"You never know what they are going to do" or "They might do anything," and this very uncertainty constitutes the real threat.

In a very real sense, too, people view a psychotic illness as irremediable, despite the fact that, as I indicated earlier, most people say psychotics get better again. But, when we look at it more closely, the most frequent position is that, though they can get better again, they can never again be the same. In fact, only a third of the American people believe that psychotics can generally recover again to a point where they will show no signs of their former illness, whereas 37 per cent believe that most will always show signs of the illness. (This last group, of course, is exclusive of the 11 per cent who do not believe any degree of recovery is possible and who, by definition, would also feel that they continued to show signs of illness. The remaining 19 per cent of the public are in varying stages of doubt about whether recovery is usually possible at all or, if so, to what extent.) We failed to ask exactly what these stigmata were that the recovered patient would always bear, but if I had to venture a guess or an interpretation, I would say that the very presence of a former patient reminds people of the existence of a threat they would rather forget, and the resulting disquietude is attributed to something about the ex-patient. And, again in a very real sense, given people's premises, there is something different about the patient. He is a kind of skeleton at the feast who has, in having become ill at all, exposed a potentiality, which he, at least, can never thereafter deny and his presence makes everyone too acutely conscious of it.

It certainly seems to be something along these lines that accounts for the fact that 60 per cent of the American people indicate that they would not feel or act normally toward an ex-patient, even if they did not learn this fact about him until after they had known him for a while without noticing anything wrong with him. This group indicates that they would be afraid and would feel a kind of unease and uncertainty in dealing with him quite akin to their feelings about the dangerousness of psychotics. Knowledge of the fact of his former illness introduces for the majority of the public, a precariousness into the relationship: people feel, as they put it, "a dread that they might go off again" or "unsafe, not knowing when it's going to happen again" and, as a result, prefer to avoid contact or, if in it, would act awkwardly and unnaturally in their efforts to avoid what they fear.

Again, in people's own words, "The very thought of their having been insane would always be with me, I'd always be thinking about it and feel I had to be cautious in anything I might say or do." Or, "I'd be careful not to say anything that might disturb or irritate her." And, although some 38 per cent of the public deny that they personally would respond like this, only 15 per cent believe that freedom from such reactions would be typical of the general public.

This complex of attitudes toward psychosis is, I suppose, the sort of thing people have in mind when they talk about a kind of atavistic fear. Certainly, the attitudes go beyond any set of rational considerations we can uncover. Take, for instance, people who said that most psychotics can recover completely with no signs of their former illness and that most psychotics aren't dangerous in any sense, even when ill. Then why should it be that two-fifths of this group still feel the same hesitancy, fear and discomfort at the idea of associating with an ex-patient that I have just described? It is true that this figure is a good deal lower than that for the other extreme of the population--people who believe recovery is generally impossible and that psychotics are usually dangerous--where the distrust of the ex-patient might be viewed as a reasonable outcome of beliefs that he is not really or wholly cured and is dangerous when ill (79). But there still remains the question of what bothers the people who say nothing about psychosis that might explain their fears of the ex-patient. It is just the evidence of such paradoxes as these which lead us to feel that the totality of the many different kinds of data we have all points to a very basic and widespread fear, however buried it may be--a fear in each individual that he too may be overwhelmed by irrationality--and a consequent withdrawal from and avoidance of anything that activates that fear.

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Where this leaves us today is something like this: on the one hand, there is an old, socially-sanctioned, well-established set of views which supports the identification of mental illness only with violent, extreme psychosis and, within this context of ideas, mental illness emerges more or less as the ultimate catastrophe that can befall a human being. This is the orientation people are using when they deal with or think about other individuals or human behavior generally and when they respond emotionally to the term mental illness. On the other hand; ours is a literate, educated population, and they have encountered in the various channels of information a rather different point of view. According to this doctrine, and it is usually presented as a fact rather than as a point of view, all manner of emotional disturbances belong within the general category of mental illness. So, when we ask people to consider abstractly and intellectually, the question of just what mental illness is supposed to cover, it is this modern definition that they give us. We are, in other words, in a period of transition in which the modern definition of mental illness has been rather widely disseminated without anything like an equal acceptance of the point of view about the nature of mental illness and about the roots of human personality and behavior which lies back of this usage of the term. It is a definition which people simply cannot work with in practice within the context of their fundamental beliefs about human behavior. Most people simply don't try to; once having stated the definition in answer to our questioning, they thereafter revert to their own more familiar way of thinking. The people who do try to reconcile the two usually end up with some dilemmas and awkward compromises; for instance, the most common reconciliation is to assume that mental illness is also a term referring to a variety of character defects--that is, to disapproved behavior for which the individual is held morally responsible. People who arrive at this position say things like, "I wouldn't say he is mentally-ill because maybe the poor fellow can't help being like that" or "He could overcome those feelings if

he wanted to so it must be a mental illness when he lets them get him down." This, of course, makes room for the neuroses and other emotional disorders within the category of mental illness, but it in no way changes the essentially moral approach to them which activates most people's inability to assimilate them fully to the category of mental illness.

In view of the lateness of the hour and the program that still is to follow, I won't take the time to expand that rather cursory reference to the public's image of non-psychotic disorders, which image exists whether or not people agree that they should be called mental illness. Neither am I going to try to say anything at all about the popular status of psychiatry, another topic that our study attempts to cover. I do want to take a last minute to make two final points, however.

First of all, I don't want to leave you with the impression that a solid and unbreechable wall of opinion exists. Obviously we are suffering from an embarrassment of riches in this study, as evidenced by our difficulties in organizing the materials for publication, and, in a relatively brief presentation like this, I've had to be stringently selective. But, if, in place of the topic of "What the Public Thinks," I had been asked to comment instead on "Who Thinks What," there would have been a somewhat different picture placed before you. Ours is a complicated, heterogeneous society--groups differ--etc. So, in emphasizing as I have the dominant modes of thought, majority opinions, main tendencies, I hope you have not lost sight of the fact that all of these were far from unanimous. It is in the deviant, minority thinking that the beginnings of change are usually seen, and these signs of change are there, if I had time to report them.

Nevertheless, and this brings me to my final point, I think that we must all soberly recognize that when we talk about the long-run aims of mental health education, we are talking about bringing about a veritable revolution in people's ideas about some very fundamental questions. This kind of change can occur, and I am certainly not here today to offer councils of despair, doubt or defeat. I would only suggest that fundamental changes are slowly and painfully achieved; usually far too slowly to satisfy the people who are laboring to bring them about. Perhaps by facing squarely the enormity of the task, we will all be more proud of, or, at the very least, less disappointed and disillusioned by the relatively small changes that can be achieved in any one year or even five.

(Thank you.)