Attitudes Toward Mental Illness in a Maryland Community

JON K. MEYER, B.A.

A SERIES of investigations of public attitudes toward mental illness and the mentally ill conducted during the 1950's reached disheartening conclusions. In the words of the Cummings (*1*), the public reacts toward mental illness in a pattern of "denial, isolation, and rejection."

In 1960, during the development of a plan for home and emergency care of the mentally ill, a survey was conducted in Baltimore by Lemkau and Crocetti (*2–4*) in order to evaluate the milieu in which the program, the patient, and his family would function. Responses of the majority of persons interviewed in the Baltimore study appeared to reflect a humane and patient-oriented attitude toward the mentally ill. To test the representativeness of these results, the study has been repeated in different populations. One such effort, a survey employing portions of the Baltimore questionnaire, but using less rigorous sampling techniques was conducted in three small communities in Carroll County, Md. (*5*). The results of this study tended to confirm those from Baltimore.

The current study was undertaken to sample the opinion of an urban, though nonmetropolitan, population in contrast to the distinctly metropolitan population studied by Lemkau and Crocetti. For the purpose, the Maryland eastern shore community of Easton (1960 population 6,337) was selected.

The author is a senior medical student at the Johns Hopkins School of Medicine. *The work on which this paper is based was supported by a fellowship from the Maryland State Department of Health and by the Talbot County Health Office, Maryland State Department of Health. Dr. Helen Abbey, associate professor of biostatistics, Johns Hopkins School of Hygiene and Public Health, served as consultant on sampling and general statistical problems.*

Statistical Methods

Since block statistics were not available for Easton, the files in the billing section of the Easton Utilities Commission were used to draw a probability sample of 116 dwelling units. This source was advantageous for several reasons. Each electric meter in the town and, therefore, almost every dwelling unit was represented by an Addressograph-Multigraph plate, color-coded according to whether a residential, commercial, or rural user. The residential rate area included the town of Easton and the area 1 mile from the town line in every direction, thereby bringing new, middle class subdivisions within the scope of the survey. Excluded from residential rates were such dwellings as nursing homes, rest homes, guest and boarding houses, hotels, motels, and homes for the aged. A sample of 116 dwelling units was selected by drawing every 19th residentially coded plate.

Once the sample of dwelling units was drawn, enumeration of the members of each household, the ultimate selection of a respondent, and the interviewing were done in the same manner in Easton as by Lemkau and Crocetti (*4*) in Baltimore. The questionnaire developed and intensively tested for the Baltimore study was used in toto in this work.

One hundred interviews were completed, representing 86.1 percent of the sample. The reasons for lack of completion were diverse and, as nearly as it is possible to judge, the missed

respondents were randomly distributed by age, race, sex, and income. When compared with the 1960 U.S. Census, the interviewed sample was within one standard error of the population percentages in the categories of race, sex, and age.

Results

A major purpose of this study was to reevaluate what the Joint Commission on Mental Illness and Health, in 1961 called "society's many sided pattern of rejection of the mentally ill" (*6*). The part of the questionnaire designed to elicit this constellation of reactions can be divided into two subsections.

Subsection 1 consists of a series of stories developed by Star (describing a simple schizophrenic, an alcoholic, and a rather violent paranoid) (*7*). The stories were designed to investigate ability to recognize mental illness as well as feelings about the prognosis of the disease. After each story was read, the respondents were asked if they thought the central figure had some kind of "mental illness—a sickness of the mind—or not." Since Star's stories have been used in several surveys, it is possible to compare the results obtained by Star with results obtained in subsequent studies (*1–5, 7*).

Table 1 lists the percentages of respondents in five studies who identified mental illness in these fictitious case histories. For a sample story, see Lemkau and Crocetti, (*4*).

It is apparent that the Baltimore figures were replicated in Easton. As in Baltimore (*4*), the responses represented a consistent pattern of behavior. Fifty-two percent of the respondents in Easton correctly identified mental illness in all three cases; 29 percent in two out of three cases.

The second subsection of the questionnaire consists of a series of short statements requiring affirmative or negative responses and designed to elicit the attitudes of the respondent in hypothetical situations of varying degrees of intimacy with the mentally ill. These short statements can be divided logically into two groups, as is done in table 2. The first group is more personal, hypothesizing intimate contact with mentally ill persons; the second relates to a more impersonal constellation of attitudes toward and knowledge about the mentally ill. Statements in parts A and B are arranged in descending frequency of "nonrejecting" responses in the Easton study.

This section is comparable in full with the Baltimore study and in part with the Carroll County study. The percentages of nonrejecting responses in each of the studies are roughly parallel.

Thirteen of the 15 questions were answered in a nonrejecting manner by at least a majority of the Easton respondents. An important consideration is whether these responses represent a consistent pattern of verbal behavior. Analysis showed that 12 percent of the respondents answered all five of the first set of questions in an "accepting" manner, while 61 percent answered at least three out of five in this way. Eighteen percent answered all of the second set in a nonrejecting way, while 77 percent answered at least seven out of 10 in this manner. A similar consistency of attitude was found in the Baltimore survey (*2*).

Discussion

That there is evidence of rejection of the mentally ill in the Easton study is undeniable. In the second subsection of the questionnaire, as situations in which greater degrees of intimacy with the mentally ill are hypothesized, responses tend to become less accepting. For instance, 75 percent of the respondents were willing to work with someone who had been mentally ill, but only 44 percent could imagine themselves falling in love with such a person (table 2, part A).

The mass of the data, however, suggests that the population sampled in Easton does not tend to deny the presence of mental illness or reject the mentally ill in hypothetical situations.

The Easton reaction to Star's stories, when compared with that of the populations sampled by Cummings and Star, indicates either a greater awareness of the signs and symptoms of mental illness or a lesser inclination to deny the presence of these disorders, or both (table 1). Furthermore, since the Easton responses duplicate with precision those from Baltimore and Carroll County, it would appear that the

public perception of mental illness indicated by the reaction to these anecdotal case histories is a phenomenon reproducible in high degree within the State of Maryland.

There is no such precise relationship among the responses elicited in the three Maryland studies to the statements in subsection 2 of the questionnaire (table 2). The trend was for the respondents to react verbally in a nonrejecting manner both to hypothetical situations of in-

Table 1. Percent of respondents stating that the central figure in each of the three stories developed by Star was mentally ill

Story illustrated	National sample, 1950 (7) (N=3,500)	Canadian town, 1951 (1) (N=178)	Baltimore, 1960 (4) (N=1,737)	Carroll County, 1961 (5) (N=139)	Easton, 1962 (N=100)
Alcoholic	[1] 29	25	62	[2]	63
Schizophrenic	[1] 34	36	78	[2]	77
Paranoid	[1] 75	69	91	[1] 89	89

[1] Unpublished data. [2] No comparable question.

Table 2. Percent of respondents answering in a nonrejecting manner when questioned about hypothetical situations of some intimacy with the mentally ill

Statements	Response	Baltimore (2, 3) (N=1,737)	Carroll County (5) (N=139)	Easton (N=100)
Part A				
1. I wouldn't hesitate to work with someone who had been mentally ill.	Yes	81	[1]	75
2. If I could do the job and the pay were right, I wouldn't mind working in a mental hospital.	Yes	68	[2] 51	57
3. I would be willing to room with someone who had been a patient in a mental hospital.	Yes	51	[1]	55
4. We should strongly discourage our children from marrying anyone who has been mentally ill.	No	[2] 46	[2] 38	45
5. I can imagine myself falling in love with a person who had been mentally ill.	Yes	51	[1]	44
Part B				
1. There are many different kinds of mental illnesses	Yes	92	[2] 95	94
2. People who have some kinds of mental illness can be taken care of at home.	Yes	[2] 84	[2] 84	89
3. The best way to handle people in mental hospitals is to keep them behind locked doors.	No	77	[2] 79	88
4. If someone living in the same family with me became mentally ill, I would certainly try to take care of him at home, if the doctor thought it wouldn't do any harm.	Yes	83	[2] 98	87
5. Sometimes it is better for a person with a mental illness to live with his or her family instead of being in a mental hospital.	Yes	74	[2] 79	81
6. Almost all persons who have a mental illness are dangerous.	No	74	[2] 80	78
7. All people with the same mental illness act in the same way.	No	83	[2] 90	76
8. Every mental hospital should be surrounded by a high fence and guards.	No	62	[2] 64	69
9. Everyone who has a mental illness should be placed in a mental hospital.	No	[2] 58	[2] 76	61
10. People who have been in a State mental hospital are no more likely to commit crimes than people who have never been in a State mental hospital.	Yes	[2] 59	[2] 65	57

[1] No comparable question. [2] Unpublished data.

timacy with the mentally ill (table 2, part A) and to propositions constructed to facilitate expression of hostile feelings toward the mentally ill (table 2, part B). Fifteen statements from subsection 2 of the questionnaire were presented to the Easton and Baltimore respondents; 12 were presented to the Carroll County respondents. In Easton 13 of 15, in Baltimore 14 of 15, and in Carroll County 11 of 12 statements elicited nonrejecting responses from at least a majority of the respondents.

Conclusion

Results of the Maryland studies appear to indicate, first, that the population sampled is rational and humane in its verbally expressed attitudes toward mental illness and is aware of the signs of some mental disorders; second, that these results can be replicated in markedly different communities within an eastern seaboard State; and third, that although the exact relationship of the Maryland studies to earlier studies cannot be stated, apparently a significant change in verbally expressed attitudes toward mental illness has occurred in the last 10 years.

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HEW Committee on Alcoholism

Secretary of Health, Education, and Welfare Anthony J. Celebrezze has appointed a Department Committee on Alcoholism to be responsible for coordinating all departmental activities concerned with this disorder. The Department currently spends nearly $4 million annually on research and rehabilitation efforts to reduce alcoholism.

Five million persons are estimated to be victims of alcoholism in the United States today, and 200,000 new cases occur annually. In announcing formation of the committee Secretary Celebreeze said, "Alcoholism is one of our greatest public health problems. It causes untold damage to the victim, his family, and the Nation's productivity. The problem is old, the solution nearly nonexistent. I have therefore directed the committee to recommend a cohesive and workable program within HEW to see if we can reduce the growing number of alcoholics in this country."

Dr. William H. Stewart, an Assistant Surgeon General of the Public Health Service and staff assistant to Secretary Celebrezze, will serve as committee chairman. Edward S. Sands, consultant on alcoholism to the Public Health Service, will be the executive secretary.