Surveys of Public Opinions and Attitudes About Mental Illness

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THE CURRENT EMPHASIS on community-based treatment of mental disorders and on viewing mental illness in terms of social malfunction has focused increased attention on community attitudes about mental illness and the mentally ill. An appraisal of the present status of public opinions and attitudes about mental illness is essential in planning effective educational programs designed to reach specific target audiences, each with its own different background and special frames of reference. This paper summarizes the findings of a number of surveys of such opinions and attitudes made during the past 15 years and suggests certain implications of these findings for programing communications activities.

Educational-Occupational Influence

One of the earliest surveys, reported by Ramsey and Seipp in 1948 (*1*, *2*), was designed to obtain research data on opinions and information of a representative urban group regarding causative factors associated with mental disease. A standard questionnaire was used in interviewing a representative sample of 345 persons, 18 years of age and older, in Trenton, N.J., a typical, middle-sized American city of 125,000 population. Data were correlated according to age, sex, race, religious affiliation, educational level, and occupational class.

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This survey revealed what has been confirmed by several later surveys. The higher the educational and occupational level of the respondent, the more "enlightened" were his opinions about mental illness: the more optimistic he was about likelihood of recovery, the greater his tendency to recommend professional treatment, the more frequently he qualified his response about the possibility of hereditary factors being involved in mental illness, the less often he associated sin and "insanity," the less he believed it is harmful to associate with the "insane," and the less frequently he cited poor living conditions as a cause of mental disease.

Facts Alone Do Not Convince

Community mental health education programs often have been based on a premise congruent with these findings. Assuming that attitudes about mental health are linked to level of education and knowledge of psychiatric concepts, those who have planned such programs have stressed providing the public with the facts about mental illness. However, a 1960 report (*3*), based on data from a 1950 survey, raised serious question about the validity of this assumption. The survey, conducted by the Washington Public Opinion Laboratory, was designed to answer two questions: (*a*) Are the opinions that people have about the etiology and prevention of mental illness related to the level of their formal education? (*b*) Are these opinions related to their familiarity with the technical vocabulary of psychiatry?

Findings from 438 interviews of a sample population in the State of Washington revealed

that "opinions regarding the etiology and prevention of mental illness are only slightly, if at all, related to the level of formal education and . . . only weakly correlated with knowledge of the technical vocabulary of psychiatry" (*3a*). The only strong correlation was between level of formal education and knowledge of the technical vocabulary of psychiatry.

It probably is rash to conclude from this one study that knowledge has little influence on opinions and attitudes toward mental illness. The study substantiates earlier findings that giving people "the facts" will not necessarily alter their opinions. The authors conclude their report by suggesting the need for basic research on "frames of reference by which persons integrate factual information and personal opinion. Such research would [provide guides for] . . . more realistic community mental health programs" (*3a*). The desirability of such research is underscored by two more recent surveys. One (*4*) revealed a relatively high level of sophistication about mental illness in a poorly educated, low socioeconomic urban population. The other (*5*) showed a relatively low mental health orientation in civic leaders who had had much contact with the mentally ill.

Reluctance To Seek Psychiatric Help

During the summer of 1950, a study was made of the attitudes of the citizens of Louisville, Ky., on the general subject of mental health. One in every 90 persons, or a total of 3,971 residents aged 18 and over, were interviewed in their homes by trained interviewers provided with carefully prepared questionnaires. Each interview lasted 45 minutes. Representative samplings were made of various age groups, income and educational levels, races, and both sexes. A special survey also was made of four occupational groups: physicians, lawyers, clergymen, and teachers (*6, 7*).

The younger age groups and the better educated revealed a more humanitarian and scientific outlook than the older and less well-educated groups, but the majority of all ages expressed relatively enlightened views about the need for medical treatment of mental illness and an awareness of the lack of sufficient physicians and hospitals in Louisville to provide that treatment. Although the respondents supported psychiatry and medicine in general, the survey revealed a lack of recognition of psychiatric problems as such. Most people favored consulting the family physician, the clergyman, members of the family, or friends before "resorting" to psychiatry for help with emotional disorders.

The Louisville survey revealed that the attitudes of lawyers differ from those of the other professional groups surveyed. Approximately 25 percent of the lawyers favored punitive measures for dealing with juvenile delinquency. More than 40 percent were opposed to seeking the help of a psychiatrist when someone acts strangely. More than two-thirds endorsed secrecy about mental illness in the family. Teachers, physicians, and clergymen did not differ so much among themselves as they differed from lawyers. Since lawyers often are consulted by people at critical junctures in their lives and when they are emotionally upset, a vigorous program of mental health orientation for the legal profession seems to be indicated.

Exposure to Information

One of the most revealing indications of the complexities of attempting to influence public attitudes toward the mentally ill is contained in the 1950 analysis of the nature of popular thinking about mental illness by the National Opinion Research Center (NORC) of the University of Chicago. The study (*8–11*) was comprised of 3,500 intensive interviews, each lasting 1½ hours, with a representative cross section of the American public. Its goals were to describe the characteristic ideas about mental illness that are current in our society and to explain the formation of these popular concepts.

The survey results indicate that the average American knows that mental illness can be treated and that treatment entails special facilities, institutions, and the services of psychiatrists. More than 70 percent of the respondents indicated that they believed a psychotic can recover, but only about 20 percent believed that the condition of most psychotics actually improves. Their reasons were: not enough treatment facilities and people do not seek help early enough.

The personality and behavior of six mentally ill persons were briefly described: paranoid, simple schizophrenic, alcoholic, anxiety neurotic, childhood conduct disturbance, and compulsive-phobic. Interviewees were asked to tell whether they thought anything was wrong with each person, what was wrong, what could have caused the condition, and whether the person should be regarded as mentally ill.

One-sixth of the 3,500 interviewees did not categorize any of these cases as mental illness. One-third saw mental illness only in the paranoid patient. Of the 43 percent who recognized mental illness in the other patients, only half, or about one-fifth of the total group, recognized neurotic symptoms as a manifestation of illness.

In general, the people who had included neurotic as well as psychotic symptoms in their definition of mental illness tended to perceive mental illness in more of the patients than those who did not. But there was a great disparity between intellectual appreciation and concrete recognition. Although many interviewees began their discussion by saying that there are all kinds and degrees of mental illness, they ended by admitting only extreme psychosis into their actual working definition.

Interesting differences in attitudes, traceable to social and other factors, were revealed by the NORC survey. The views of the people who reported that they had a great amount of exposure to information about mental illness from newspapers, books, lectures, articles, radio programs, and other sources were more likely to approach professional views. The amount of education of the respondent was directly correlated to his concern with social problems, his knowledge about mental illness, and the number of information sources from which he derived that knowledge. At every educational level, however, people who derived their information about mental illness from a greater number and variety of information sources were more knowledgeable than their educational peers. High school graduates with high exposure to information sources perceived each of the six patients as mentally ill more often than college graduates with low exposure to information sources.

NORC respondents who knew persons receiving psychiatric treatment tended to be more knowledgeable about mental illness. Those who knew noninstitutionalized psychiatric patients read and listened to more information about mental illness than those who knew patients in mental hospitals. The general educational level may have been a factor here since findings from another study (*12*) indicate that private psychiatric care is associated with higher socioeconomic class status. The respondents in or near large metropolitan centers were most likely to have contact with patients receiving psychotherapy. If contact with patients receiving noninstitutional psychiatric care is correlated with greater knowledge about mental illness, one may expect changes in public attitudes as the number of community-based psychiatric treatment centers increase.

Uninformed Rather Than Misinformed

One of the most ambitious studies of public attitudes toward mental illness was conducted over a 6-year period (1954–59) by a team of research investigators at the Institute of Communications Research, University of Illinois (*13*). In an attempt to develop improved guidelines for mental health information programs, these investigators measured opinions and attitudes of the public and of specialists in the mental health field, analyzed the mental health content of the mass media, and studied methods of effecting changes in public attitudes and opinions. The surveys of popular information and attitudes were based on samples of 100 to 700 people. Extensive use was made of an "opinion panel" of some 400 people, most of them from central Illinois but representative of the United States as a whole with regard to education, sex, income, religion, and race.

Respondents in the Illinois study did not have logically grouped patterns of opinions. They were unsure of their beliefs and were willing to change them fairly readily. They differed most from the experts in believing that a person can read or control himself into mental health or be taught good mental health. Public attitudes toward the mentally ill were found to be largely negative. The mentally ill were regarded with fear, distrust, and dislike, and thought to be unpredictable. Psychotics were held in lower esteem than neurotics; neurotics

were considered to be weaker and psychotics less predictable. The interviewees had moderately high positive attitudes toward mental health professionals, but mental treatment methods and institutions were held in relatively low esteem.

Nunnally's group sampled the mental health content of the mass media (*13*). They found that information about mental illness appears relatively infrequently and that the mass media generally present a distorted picture of mental health problems. The investigators mention two mitigating circumstances: (*a*) The public probably is able to discriminate between valid and unrealistic presentations and undoubtedly learns something from the better media presentations, however rare they are, and (*b*) the content analysis of the mass media was made in 1954 and 1955, and presentations about mental health and mental illness may have improved since then.

The Illinois survey reports that the general practitioner has a "good" opinion about psychiatry. The general practitioner reported "high" regard for the psychiatrist but tended to have the same negative attitudes toward the mentally ill as does the lay public. Younger and better informed physicians had more enlightened attitudes toward mental illness and were more apt to treat mental patients.

In summary, the Illinois group concluded that the public is uninformed rather than misinformed about mental illness, that they are unsure of their opinions and look to the experts for assurance. Negative attitudes toward the mentally ill are based on the unpredictability of sick behavior. People want information to help relieve the personal threat that mental illness poses for them. They want solutions, not anxiety. Destruction of preexisting information without providing new information results in negative attitudes.

Accepting Attitudes in Recent Studies

Before establishing a plan to provide emergency and home care services for psychiatric patients, the success of which would depend to a large extent on community acceptance, health authorities in Baltimore decided to obtain information about public attitudes toward mental illness and the mentally ill (*4*). Previous studies had characterized these attitudes as "denial, isolation, and rejection," but the Baltimore survey, conducted in 1960, failed to support this point of view.

The population (1,736 persons over 18, randomly selected) sampled by Lemkau and Crocetti (*4*) was from a relatively low socioeconomic group with a median family income of $4,730. The median age of respondents was in the low thirties, and the median education was 9.7 years of formal schooling. Many of the respondents were recent migrants from the South to this underprivileged section of Baltimore, where the emergency service was to be centered.

Three of the case stories from the NORC survey were used. The most striking contrast between the responses of this sample population and those in previous studies was in their ability to identify descriptions of behavior as indicative of mental illness. Age, race, marital status, and urban or rural birth were not significantly correlated with the tendency to identify the condition as mental illness. As in most other studies, however, education and income did make a difference. The greater the amount of education and the higher the income, the greater was the likelihood that the person would recognize mental illness. The big difference between this and most other studies was the high proportion of the least educated who identified all three cases.

There was no strong evidence of rejection of the mentally ill. Half of the respondents said they could imagine themselves falling in love with someone who had been mentally ill, and half said they would be willing to room with someone who had been a mental patient. Eighty-one percent said they would not hesitate to work with a person who had been mentally ill; 62 percent disagreed that "almost all who have a mental illness are dangerous." Eighty-five percent agreed that people with certain kinds of mental illness can be cared for at home, and 60 percent agreed that people who have been in a State mental hospital are no more likely to commit crimes than those who have not been in such a hospital. In all, only about 15 percent of the respondents could be categorized as rejecting or wanting to isolate the mental patient.

Relatively favorable attitudes toward the mentally ill also were noted in two other studies conducted in Maryland. One, a survey (unpublished) of three small communities in Carroll County, reported by Mary Lemkau while an undergraduate student at Western Maryland College, revealed that most of the public were humanely patient oriented. The other survey, reported by Meyer (*14*), repeated the Lemkau and Crocetti (*4*) study in Easton, a small town on the Eastern Shore of Maryland with a population of about 6,500. Easton is a fairly prosperous town, characterized by small businesses and small farms. It also has a relatively stable population; 89 percent of the 100 interviewees had been in Easton 5 years or more and 22 percent were lifetime residents. Respondents in the Easton study demonstrated the same ability to recognize mental illness and the same tendency to be nonrejecting of the mentally ill as did the respondents in the Baltimore study. As in so many other studies, youth, income, and education were correlated with ability to recognize mental illness and acceptance of the mentally ill.

Effect of Occupational Frames of Reference

Representatives of the upper end of the socioeconomic status scale were surveyed in a 1960 study by Bruce P. Dohrenwend (*5*). Conducted in a "bedroom community" for New York City's commercial and industrial center, a densely populated lower middle-class and working-class district, the survey concentrated on the orientation of the civic leaders in this urban area toward problems of mental illness. Questionnaire interviews, each lasting 1¾ hours, were held with leaders from each of the four main ethnic groups (Jewish, Irish, Negro, and Puerto Rican) and from the politicolegal, economic, religious, and educational institutional orders.

The politicolegal order was composed of 31 percent of the leaders including State senators, district leaders, State assemblymen, city councilmen, heads of organizations like the League of Women Voters, municipal court justices, and police captains. The economic order (16 percent of the leaders) was composed mainly of high banking officials and heads of large businesses. The educational order, with 29 percent of the leaders, included a university president, an assistant superintendent of schools, public school principals, and the chairmen of local boards of education. The religious order (16 percent) included Catholic, Jewish, and Protestant clergymen. The remaining 8 percent were heads of Puerto Rican social-recreational clubs.

The respondents were presented with the six case descriptions of mental disorders used in the NORC survey. They were asked to express their judgments about the presence of mental stress in these patients, the seriousness of the illness, and whether they would recommend help from the mental health professions. The central purpose of the survey was to determine whether the orientation of the leaders varied with their institutional order.

Recognition of the presence of mental illness was much greater than in the NORC survey and more on a par with the experience of Lemkau and Crocetti in the Baltimore survey. Ethnic background did not seem to account for differences among the leaders. Neither did contact with mental illness. Education had some effect but did not alter the basic differences among the different institutional orders. These basic differences follow:

	Tendency to—		
Professional group	*See case as mental illness*	*Regard conditions as serious*	*Recommend help from mental health professionals*
Educational leaders.	High-----	High-----	High.
Politicolegal leaders.	Relatively high.	Relatively low.	Relatively high.
Religious leaders.	Relatively low.	Relatively high.	Relatively low.
Economic leaders.	Low-----	Low-----	Low.

The high tendencies of the educational leaders and the low tendencies of the economic leaders agreed with expectations. The politicolegal leaders were closest to the educational leaders in psychiatric orientation but low in the seriousness quotient. The investigators theorized that perhaps their legal background led them to think of behavior disorder as serious in the likelihood of harm to others rather than to the patient himself.

The orientation of the religious leaders was unexpected, and the investigators felt that this orientation appeared to be competitive with

psychiatry. They pointed out that although 70 to 80 percent of the religious leaders have had contact with the mentally ill, as compared with only 30 to 50 percent of the educational leaders, their orientation to mental health was relatively low. The investigators theorized that the differences were traceable to the varying frames of reference which govern activities in the different professional and occupational groups and which serve as the basis for their appraisal of deviant behavior. The theory that professional and occupational frames of reference determine people's attitudes toward mental illness suggests that there really is no common cultural approach to the subject and that no simple strategy of mental health education will suffice to alter public attitudes for the better.

Felt Need a Factor in Seeking Help

The second half of a nationwide interview survey, "Americans View Their Mental Health" (*15*), conducted as part of the work of the Joint Commission on Mental Illness and Health, was devoted to a study of the way in which Americans approach or fail to meet their mental and emotional problems. The findings distinguished two sets of factors in whether or not a person seeks professional help for an emotional problem: (*a*) psychological factors, or readiness for self-referral, and (*b*) facilitating factors, such as availability of resources in the community, public knowledge about these resources, and local social customs about whether and where it is appropriate to seek help.

Twenty-eight percent of the people who used professional help for personal problems were referred by outside sources. Eight percent were referred by physicians; 1 percent by clergymen; 8 percent by family or friends; 3 percent by school, court, and other civic agencies; 1 percent by mass media, and 7 percent by other referral agents.

Of those who did not mention outside referral, 29 percent said they sought the kind of help they did because the source seemed "functionally appropriate" for the problem. Forty-two percent consulted clergymen; 29 percent, physicians in general; 18 percent, psychiatrists or psychologists; and 10 percent, social agencies or marriage clinics.

To the extent that people do not get the most effective kind of help for their emotional problems, either because "helping" persons and agencies in the community do not refer them to the appropriate sources or because they themselves have incorrect concepts about appropriate sources, this is a fertile area for public information and education.

Another fertile area for educational efforts is revealed in the reason given by people who felt they could have used some help but did not ask for it. Twenty percent of this group said they did not know how to go about seeking help. Fourteen percent said they felt that seeking help would involve shame or stigma. Only 4 percent said that the expense deterred them. The investigators hypothesize that the greater use of psychiatric help by high-income groups is related more to the social climate in which they live than to their high income. For each population subgroup, the investigators found that the availability of more psychiatric resources is associated with a greater tendency to seek help from all kinds of mental health facilities. This impact, however, would apply only to those people who structure their problems in pyschological terms. The fact that the person "felt the need" is a crucial element.

Attitudes of Mental Health Workers

A 1963 study, supported by the World Federation for Mental Health, investigated the attitudes toward mental illness among the general population and the attitudes toward mental patients and their rehabilitation among mental health personnel (*16*).

Attitudes of mental health personnel toward patients varied with the social class and occupation of the staff member. In general, the staff tended to find it easiest to work with patients who were closest to their own socioeconomic status. Psychiatrists and psychologists preferred to work with middle- and upper-class patients and with younger and better-educated patients. Social workers said they preferred to work with middle-class patients. Ward personnel preferred the older and less aggressive patients.

Attitudes favorable toward potential for patient rehabilitation tended to decrease as one went down the mental hospital's social scale from psychiatrists to attendants. The investigators found that the policies set by top admin-

istrators of the hospital had little effect at the ward personnel level. Since the attendant symbolizes the mental hospital for the average patient, the question arises as to whether the patient views the attendant's attitudes as a reflection of basic hospital values. These findings indicate the need for more effective intra-agency communications to insure that all personnel understand and carry out the official treatment policy. Special measures are also required to motivate ward staffs to see their function in rehabilitating mental patients rather than in merely maintaining peace and order.

The second part of the World Federation study concerned occupations in which people are willing to trust mental patients (*17*). For the most part, the respondents did not feel that former mental patients would be able to make important decisions, supervise others, and work in close contact with other people. They recommended that former mental patients would probably do best in jobs requiring relatively little responsibility and skill, in jobs with little prestige, and in unconventional jobs. Such attitudes pose a dilemma. Former mental patients may find it easier to get less-skilled jobs, but they will be working with people in socioeconomic status groups with less-tolerant attitudes toward the mentally ill.

Another important finding of this study was that expressed attitudes seemed to vary with the way in which questions were posed. The investigators found that when they formed their questions in personal terms—Would you be willing to take a job alongside a mental patient? Would you be willing to hire a former mental patient? Would you be willing to work for a man who has been a patient in a mental hospital?—they tended to get more tolerant and favorable responses than when they asked impersonal questions, such as: Should employers hire former mental patients? Even those people who were most distrustful of the mentally ill did not differ much from the most trustful in being willing to actively help a close friend or relative who had been a mental patient.

Conclusions

A review of these surveys conveys the impression that a forward motion has developed during the past decade in better public understanding of mental illness and greater tolerance or acceptance of the mentally ill. It appears to be reasonably clear that the public does not universally reject the mentally ill nor is it thoroughly defeatist about the prospects of treating mental illness. Certainly, any program of public education must seriously take into account the strong likelihood that many varieties of public opinions and attitudes about mental illness exist in the total population and that these are far from static.

The findings of the studies, relating opinions and attitudes about mental illness to educational and occupational levels, indicate the need to address special mental health educational efforts toward people in the lower socioeconomic groups, who are less likely than the more prosperous to seek psychiatric help before the patient's condition becomes acute. Investigations by Hollingshead (*18*) have demonstrated that proportionately more of this group become chronic cases in the back wards of the large public hospital. Unfortunately, people in the lower socioeconomic groups are not "joiners" in the middle-class sense, and it is hard to find convenient target groups through which to reach them. Yet they are precisely the people who must be reached. Mental and emotional disorders compound their social problems and reduce the effectiveness of their already limited resources. Better public health control programs for mental illness among the poorer and the less well-educated segments of the population can be an essential weapon in any war against poverty.

The findings of the surveys that younger people and those who have been exposed to much information about mental illness have more enlightened opinions suggest the need for continuing comprehensive programs of mental health education addressed to all levels of the population and designed to reach the same people many times and in many different ways. There is question, however, about the content of such educational efforts. Mere intellectual understanding of a problem does not necessarily result in the desired action. The surveys in which different professional groups and different categories of mental hospital employees were interviewed emphasize the importance of the person's special interests and his special frame

of reference. These and other similar findings point to the need for well-defined, concrete, purposeful objectives in mental health educational activities.

It is important to find out what people want to know and what they need to know. In 1963 Jacqueline Bernard, then a psychologist with the Minnesota State Mental Health Authority, reported a study (unpublished) designed to answer these questions as a necessary prelude to developing a program of mental health information for members of homemaker groups in rural areas and small towns in Minnesota. Her findings underline the importance of really communicating with target audiences, not merely telling them what we think they should know. When asked what kinds of information the public should be given, the homemakers most often requested answers to questions such as: How should the public treat the mentally ill? How should one behave toward a patient discharged from the mental hospital? What can we do for the mentally ill? When asked the same questions, mental health professionals in the State said they thought that the public should know about etiology and symptoms of mental illness, prognosis, social and financial costs, and modern treatment methods and philosophies.

The fact that people are interested in how they should behave toward specific mentally ill persons is in itself a promising sign. Experience with mental hospital volunteer programs has indicated that volunteers who have direct contact with patients are very knowledgeable about mental illness and generally understanding toward the mentally ill. The findings in the study conducted under the auspices of the World Federation for Mental Health (*16*, *17*) which stressed the importance of the personal element, and the report by Gurin and co-workers (*15*) associating availability of psychiatric resources with increased tendency to seek help, point to a relationship between attitude change and behavior change. Behavior change, through direct contact with or involvement in mental health programs, may often be the necessary prelude to attitude change. The rapid development of community-based treatment centers perhaps can, by contact and example, do more than anything else to alter attitudes which interfere with the success of modern treatment programs. The effective transmission and interpretation of pertinent information about these resources is essential to their optimum use and must be a fundamental ingredient of the mental health center's program.

Summary

Surveys of public opinions and attitudes conducted during the past 15 years demonstrate increasing public understanding of mental illness and greater acceptance of the mentally ill. Findings indicate that younger people, the better educated, and those in higher status occupations usually hold more enlightened opinions. A person's professional frame of reference may affect his attitudes about mental illness and how the mentally ill should be treated. The degree of exposure to information about mental illness and to psychiatric patients also is an important factor, sometimes more important than formal education, in determining degree of enlightenment.

Several important implications for programing communications activities emerge from these studies of public opinions and attitudes:

- People need to be told where to go for help with emotional problems.
- Special educational programs must be developed for persons in population subgroups, where it still is considered shameful to seek psychiatric help.
- People need to be exposed to information about mental health and mental illness many times and in many different ways.
- Educational activities should have well-defined, concrete, purposeful objectives, and should be geared to the prospective audience's frame of reference.
- Before undertaking to teach people about mental health and mental illness, it is most important to find out what they want to know and what they need to know.

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1965 Revision of Milk Ordinance

Copies of the 1965 revision of the milk ordinance recommended by the Public Health Service are now available. "Grade *A* Pasteurized Milk Ordinance—1965 Recommendations of the United States Public Health Service" (PHS Publication No. 229) represents the 13th revision since the first ordinance was published in 1924 and supersedes one published in 1953.

By the end of 1964, the Service-recommended milk ordinance had become the basis of milk regulations or law in 37 States. In addition, more than 1,900 communities, encompassing almost 110 million persons in 40 States, had voluntarily adopted its provisions. Recognized by the milk industry and many others as the national standard for milk sanitation, the ordinance is the standard used in the voluntary cooperative State-Public Health Service program of certification of interstate milk shippers, is referenced in Federal specifications for procurement of milk and milk products, and serves as the regulation for milk served on interstate carriers.

The 1965 recommendations are designed to meet the complex problems in sanitary control of milk products arising because of new products, processes, chemicals, materials, and marketing patterns. As in earlier revisions, milk sanitation agencies at every governmental level, milk producers and processors, industry associations, education and research institutions, and individual professions aided in developing the new recommendations, which represent a consensus of current knowledge and industry practice.

Copies of the new ordinance may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402, for $1.25 each.