Public Acceptance of the Mentally Ill

An Exploration of Attitudes

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CONSIDERABLE attention was given to public attitudes about mental illness and the mentally ill in the United States during the late 1940's and early 1950's. The major mental health programs were being launched by Federal and State Governments, and popular support was needed to endorse the extensive expenditures required by this effort.

With the advent of the community mental health center program and the new emphasis on community-based treatment of the mentally ill, the public's attitudes again assume critical importance. Public understanding and favorable attitudes are essential for optimum utilization of the new types of mental health facilities and for acceptance of the greater number of mentally ill persons who can now be treated in the community.

In the 20 years since the establishment of the National Institute of Mental Health, a number of surveys have been made to assess the American public's opinions and attitudes about mental illness. These surveys have been made at different times, by different investigators, with different research designs, and on different populations.

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Although comparisons are therefore difficult, the general impression conveyed by the results of these studies is that the public is better informed about mental illness than it was a decade or two ago and that it expresses more tolerant attitudes toward the mentally ill. Unresolved questions remain, however. Is increased knowledge about mental illness equivalent to increased understanding of such disorders? More important, in considering the role the public must play, is expression of more tolerant attitudes equivalent to increased acceptance of mentally ill persons in the community, in the home, and in the places where people work and congregate? The answers to these two questions do not appear to be unqualifiedly in the affirmative.

A new review of the results of opinion surveys would help analyze unresolved questions about public attitudes and would pinpoint areas where increased understanding and acceptance are essential to the success of the new programs.

The results of the studies are reviewed and the answers they provide to the following four questions are discussed: What is the influence of formal education and socioeconomic status on knowledge about mental illness? Are the public's opinions about mental illness beginning to approach those of the mental health professionals; if so, what effect will this have on the public's acceptance of the mentally ill? Does a person's occupational frame of reference influence his opinions about mental illness? Where do people seek help for mental and emotional

problems? In the interest of brevity, details of research design and methodology are omitted from this review. Those details are covered elsewhere (*1*, *2*).

1. What is the influence of formal education and socioeconomic status on knowledge about mental illness?

For some time, it was generally accepted that there was a direct relationship between a person's educational and socioeconomic level and his knowledge about mental illness. More recent opinion surveys indicate that poorer and less well-educated people know more about mental illness than we thought they did, that people in the higher status groups do not know as much as we thought they did, or that neither group really understands the psychodynamics of mental illness.

The principal results of one of the earliest surveys, made in the late 1940's (*3*, *4*), were that enlightened opinions were positively correlated with educational and occupational level and negatively correlated with the age of the respondent. The higher the educational and occupational level and the younger the age, the less likely the respondent was to believe many of the popular superstitions then current about the causes of mental illness, the more likely he was to recommend professional treatment for such diseases, and the more optimistic he was about the outcome of treatment.

This observation was confirmed in several later surveys. Three more recent studies seem to indicate, however, that the relationship between level of formal education and extent of knowledge is more equivocal. One study in Baltimore, Md., in 1960 (*5*) revealed a relatively high level of sophistication about mental illness in a poorly educated, low socioeconomic urban population. Another, made the same year in New York City (*6*), showed a relatively low mental health orientation of civic leaders who had had much contact with the mentally ill.

The third study, reported by Dohrenwend and Chin-Shong in 1967 (*7*), was specifically designed to investigate impressions that there is a growing acceptance of a mental health orientation toward deviant behavior and that lower status groups have even greater tolerance of deviance than do high status groups. The investigators contrasted attitudes of community leaders with those of ethnic cross sections in New York City. The results did not confirm these impressions, but they did indicate that low and high status groups define deviance in very different terms and that there is a strong tendency among less educated persons to reject what they define as deviant.

Dohrenwend and Chin-Shong (*7a*) state, "The appearance of greater tolerance of deviant behavior in low status groups is an artifact of viewing their attitudes within a high status frame of reference. When both lower and upper status groups define a pattern of behavior as seriously deviant, lower status groups are less tolerant . . . the relatively tolerant policy of upper status groups appears to be a consequence of their generally more liberal orientation rather than comprehension of the nature of psychopathology in psychiatric terms."

2. Are the public's opinions about mental illness beginning to approach those of mental health professionals? If so, what effect will this have on the public's acceptance of the mentally ill?

A review of the observations of several surveys, taken in chronological order from 1950 to the early 1960's, indicates that the public is no longer so misinformed or uninformed and that they are beginning to express opinions about mental illness that are closer to those of mental health professionals.

A broad survey of popular thinking about mental illness made in 1950 by the National Opinion Research Center of the University of Chicago (*8–11*) indicated that, in general, people admitted only extreme psychosis, accompanied by threatening assaultive behavior, into their actual working definition of such illness. Interesting differences in attitudes, revealed by the survey, were traceable to exposure to information about mental illness.

At every educational level, people who had derived their information about mental illness from a greater number and variety of sources were more knowledgeable than their educational peers who had fewer sources. High school graduates with high exposure to information on mental health were more apt to recognize mental illness than college graduates with low exposure. Respondents who knew persons under psy-

chiatric treatment, and in particular those who knew persons receiving outpatient care, tended to be relatively knowledgeable about mental illness.

The Institute of Communications Research of the University of Illinois (*12*) carried out one of the most ambitious studies ever made of public attitudes toward mental illness. In this study, conducted during the period 1954–59, these researchers concluded that the public is uninformed rather than misinformed about mental illness, and that they are unsure of their opinions and look to the experts for assurance and information.

Two more recent studies appear to indicate an increase in public knowledge about mental illness and acceptance of the mentally ill. Lemkau and Crocetti, studying a group in a decaying section of inner-city Baltimore in 1960 (*5*), concluded that youth, education, and income still made a difference, but they also concluded that a high proportion of the least educated were able to recognize mental illness. Only about 15 percent of the respondents could be categorized as rejecting or wanting to isolate the mental patient.

This study was repeated by Meyer (*13*) in a small fairly prosperous town in rural Maryland. Meyer's observations were similar to those of Lemkau and Crocetti who interpreted their observations (*5*) as possible evidence of the success of mental health education activities during the 1950's. Two other recent studies raise questions, however, about whether ability to recognize mental illness will lead to greater acceptance of the mentally ill or whether personal motives are of greater moment than knowledge in the acceptance or rejection of mentally ill persons.

Dohrenwend and Chin-Shong (*7*) question whether there really has been a gain over time in public understanding of mental illness or whether the shift consists of a superficial change in popular labeling of more types of deviant behavior as mental illness. Increased use of the label "mentally ill" may tend to increase rejection of those who are so labeled. According to Phillips (*14*), a person would be more likely to be rejected on the social distance scale if it were said he was receiving help from a psychiatrist rather than a clergyman or a physician.

The relationship between expressed social distance and acceptance or rejection of the mentally ill was neatly illustrated in a 1963 study of attitudes toward the mentally ill supported by the World Federation for Mental Health (*15*). The investigators observed that when they posed their questions in personal terms—Would you be willing to hire (work for, work alongside) a former mental patient?—they tended to get more tolerant 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.

Is a feeling of closeness more important than knowledge in increasing acceptance of the mentally ill? Does closeness or alienation follow on increased knowledge? Or does this vary with different people? Katz and Stotland (*16*) point out that most research on attitude change starts with the attitude itself and assumes a common motive pattern for all people. They suggest starting with measures of ego-defensiveness and separating subjects according to the needs their attitudes serve. Their suggestions imply that the answers a respondent gives during an attitude survey may reveal more of his own needs than of his readiness to respond to the needs of the mentally ill.

3. Does a person's occupational frame of reference influence his opinions about mental illness?

Relatively few studies have focused on the relationship between occupational frame of reference and expressed attitudes about mental illness. Those that have have indicated that attitudes of people in different occupations or professions appear to be influenced by their dominant occupational or professional point of view.

An early study of public opinions about mental illness in Louisville, Ky., in 1950 (*17*, *18*) included a survey of four professional groups: lawyers, physicians, clergymen, and teachers. The attitudes of lawyers differed from those of the other professional groups. 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, and more than two-thirds endorsed secrecy about mental illness in the family. The lawyers seemed to be reacting to delinquency as a threat to other persons in the society and to be thinking about mental illness as a legal problem attached to the status of being mentally ill.

Ten years later in 1960, there were comparable results from an indepth survey of attitudes of civic leaders in a bedroom community for New York City's commercial and industrial center (*6*). The leaders were chosen from these fields and specific occupations: (*a*) education—university president, assistant superintendent of schools, public school principals, and chairmen of local boards of education, (*b*) politics and legal affairs—State senators and assemblymen, city councilmen, judges, police captains, and persons active in politics, (*c*) religion—Catholic, Jewish, and Protestant clergymen, and (*d*) economics—bankers in executive positions and heads of large businesses.

Educational leaders led the list and economic leaders were at the bottom of the list in recognizing mental illness, regarding the condition as serious, and recommending mental health care. Political and legal leaders scored high in recognizing mental illness and recommending mental health care but relatively low in regarding the condition as serious. The investigators theorized that their legal background may have led them to think of behavior disorder more in terms of harm to others than to the patient himself. The orientation of the religious leaders was unexpected—they scored relatively low in recognition of mental illness and recommendation of mental health care, but relatively high in regarding the condition as serious. The investigators thought this orientation might indicate some competition with psychiatry, since almost 80 percent of the religious leaders had had contact with the mentally ill.

4. Where do people seek help for mental and emotional problems?

Expressed attitudes are a form of behavior. In mental health, we are more concerned with the influence of these attitudes on other forms of behavior—in particular, with how they affect whether and where people seek help for emotional disorders. Studies made at intervals from 1950 to the present indicate that there has been little change in the public's reluctance or inability to seek psychiatric care for such disorders. The cause or causes may lie in lack of resources, lack of knowledge about available resources, failure to structure difficulties in psychological terms, fear, shame, and the customary way of handling problems in one's own social milieu.

The 1950 study in Louisville (*17*, *18*) showed that most people favored consulting the family physician, the clergymen, members of the family, or friends before resorting to psychiatry for help with emotional disorders.

During the late 1950's, as part of the national reassessment of needs and resources made by the Joint Commission on Mental Illness and Health, a study was made of the way in which Americans approach or fail to meet their mental and emotional difficulties. The results of this nationwide survey "Americans View Their Mental Health" showed that 42 percent of those who sought help consulted clergymen (*19*). Only 18 percent consulted psychologists or psychiatrists, and only 10 percent consulted social agencies or marriage clinics. Of those who said they could have used help but did not ask for it, one-fifth said they did not know how to go about seeking help. A sizable proportion said they were deterred by shame or stigma. Only 4 percent said that the expense blocked their seeking help.

Whether or not a person sought professional help seemed to depend upon (*a*) psychological factors or readiness for referral and (*b*) facilitating factors, including availability of resources, knowledge about the resources, and local social customs about whether and where it is appropriate to seek help. Availability of a greater number of psychiatric resources was associated with a tendency to seek help from all kinds of mental health facilities, but the person's felt need for such services was the crucial element in whether or not help was actually sought.

A more recent study in New York City to provide information and guidance to the planners of mental health services focused specifically on the attitudes of the adult population toward the services being provided to them. The

results of the study (*20*), contained in a report entitled, "The Public Image of Mental Health Services," revealed that, although almost half the respondents said they had personal problems for which they could have used help, more than half said the person to whom they would turn in an emergency was a member of their immediate family (outside of their household). More people said they would consult physicians and clergymen than psychiatrists or counselors.

Elinson and co-workers (*20a*) stated, "There is considerable ignorance and confusion as to the roles played by the various mental health professionals and as to what their qualifications are . . . many still cannot distinguish between psychiatrists and psychologists. . . . The public is rather unaware of some of the leading institutions for the care of the mentally ill in this city."

New Yorkers believe that the main reasons why people do not seek help for emotional difficulties are fear of what people will think or say, fear of losing their freedom or of being hurt, and lack of recognition of their difficulty.

Summary

Are the people in the United States better informed about mental illness today than they were 20 years ago? A larger proportion of the public seemed to know more about mental illness and to have more enlightened attitudes than 20 years ago, but a significant proportion still were misinformed or uninformed and frightened or repelled by mental illness and the mentally ill.

Those persons with more access to the knowledge that was available—the better educated, the younger, the higher status groups—express themselves more knowledgeably on the subject. People, however, at all socioeconomic levels are more knowledgeable now than they were 15 or 20 years ago. Expression of more enlightened attitudes is an important advance in public behavior related to mental illness. But it is not clear that this advance has been matched by greater acceptance of mentally ill persons. And it has not been accompanied by a more enlightened approach to dealing with and receiving help for one's own emotional difficulties.

Personal orientation to deviant behavior, extent of liberalism in one's general outlook, occupational frame of reference, social customs in one's own primary reference groups, and the intrapsychic needs of the person are important. All these factors appeared to be as important as increased knowledge in determining a person's behavior when directly confronted with his own or someone else's emotional difficulties. Hopefully, the proximity of more mental health resources in the community will lead to changes in the way people seek help for mental illness, and these changes may in turn lead to changed attitudes.

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Progress Report on NARA Program

A total of 578 narcotic addicts have been committed for examination and evaluation under the Narcotic Addict Rehabilitation Act during the first 14 months of its operation ending August 31, 1968.

Of the 578 addicts, 530 entered the program at their own or their family's request, and 249 were committed to treatment. The National Institute of Mental Health, Public Health Service, administers the portion of the new law under which these addicts received services.

The number of patients receiving treatment during the first year demonstrates the gap which existed in referral and commitment procedures before the act was passed. Many addicts who received treatment would have been sent to jail with little hope of receiving rehabilitative services under the old system.

The National Institute of Mental Health has established aftercare services for addicts discharged from their treatment centers and awarded grants to establish six community-based treatment centers.

Most addicts committed under NARA will continue to be treated at NIMH Clinical Research Centers in Lexington, Ky., and Fort Worth, Tex., until a network of community-based inpatient facilities have been established. Treatment at one of these centers is followed by supervised aftercare in the community.

The first addicts discharged from the centers under the NARA program were referred to aftercare and rehabilitative centers last spring. By early fall, 71 had been enrolled in the aftercare program.

New comprehensive treatment centers, offering the most comprehensive and modern treatment available, are being developed in Chicago, Philadelphia, St. Louis, New York, Albuquerque, and New Haven, Conn.

Addicts may be committed to treatment under Titles I, II, and III of the Narcotic Addict Rehabilitation Act.

Title I authorizes civil commitment in lieu of prosecution.

Under Title II, an addict convicted of violating a Federal law may be examined and committed to treatment not to exceed 10 years. Title II is administered by the Attorney General's Office. Patients committed under this title will be treated in special facilities developed by the Bureau of Prisons.

Title III permits addicts to request commitment to treatment at Ft. Worth or Lexington if State or other treatment facilities are not available.