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Factors in Lay Diagnoses of Mental Illness: Closeness of Relationship and "De-Satisficing" Events

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FACTORS IN LAY DIAGNOSES OF MENTAL ILLNESS: CLOSENESS OF RELATIONSHIP AND "DE-SATISFICING" EVENTS

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Master of Arts

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Doyle E. Hull, Jr.
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APPROVAL SHEET

This thesis is submitted in partial fulfillment of the requirements for the degree of

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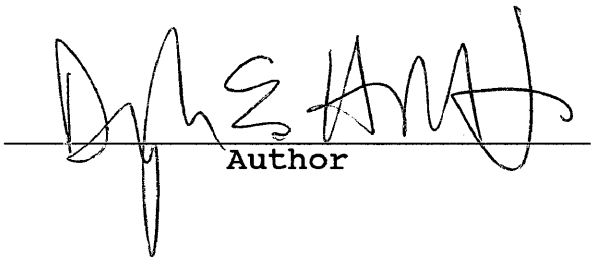

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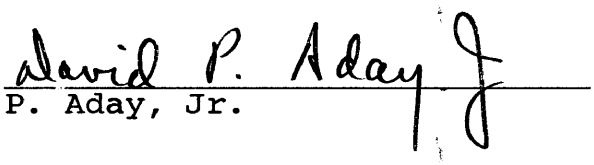

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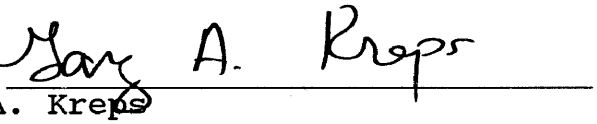

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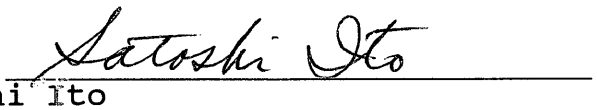

Satoshi Ito

To my parents, Doyle and Camilla Hull.

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This paper represents the end of one line and the continuation of another. The first began two years ago when I entered William and Mary's graduate program in sociology. It ends here with my thesis for that program. The second line began five years ago when I first began to think and write about mental illness. That line, I hope, will continue for many more years.

Many thank you's are in order: To David Aday for his patience and wisdom. To Gary Kreps and Satoshi Ito for their thoughtful comments. To my family for their support. And to my dear Ceci for her kindness and love.

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ABSTRACT

Sociological research has greatly increased our understanding of the negotiations which lead to lay diagnoses of mental illness. Many suggestions from this research remain unexplored, however. This study considers two of those suggestions. First, the study considers the suggestion that the closeness of relationship between decision-maker and symptomatic person might affect perceptions and explanations of symptomatic behavior. Second, the study considers the suggestion that the negotations leading to lay diagnoses of mental illness might best be seen as examples of "satisficing" behavior. The findings suggest that, although "closeness" may influence mental illness decision-making, the reasons behind its influence may be more complex than the previous research suggests. The study suggests that this complexity might be captured by a "satisficing" model.

FACTORS IN LAY DIAGNOSES OF MENTAL ILLNESS: CLOSENESS OF RELATIONSHIP AND "DE-SATISFICING" EVENTS

INTRODUCTION

Although psychiatry has developed tools for the diagnosis of mental illness, the identification of someone as "mentally ill" is usually made first by non-professional family or community members. How and why this identification comes about have been a concern in a number of sociological works. This paper presents findings from research on two particular topics within this concern: the negotiations between symptomatic person and decision-maker, and factors which affect the outcomes of such negotiations. In the following pages, I will examine the previous research relevant to this issue, detail the research problem and methods, and then present and discuss the research findings.

MENTAL ILLNESS AND SOCIAL CONTEXT

As Szasz (1987) has indicated, the concept of illness implies deviation from some sort of norm. An idea behind much of the sociology of mental illness is that the behaviors we see as "symptoms" of mental illness are ones which violate social norms (see Goffman, 1963, 1967, 1971; Scheff, 1966). Proponents of this idea hold that this is no mere coincidence. They argue the reason most "mentally ill"

persons are identified as such really has nothing to do with whatever "medical" or "mental" norms they may have transgressed and really everything to do with the social norms they have --or are said to have --transgressed.

Goffman (1963) and Scheff (1966) suggest that symptoms of mental illness run counter to what might be thought of as the "public order" --those particular social norms which determine the contexts in which behavior is "appropriate" or "inappropriate." A good example of such a norm is what Goffman formulates as the "norm of involvement":

> [This norm] is evident in the exploitation of untaxing involvements to rationalize or mask desired lolling --a way of covering one's physical presence in a situation with a veneer of acceptable visible activity. Certain minimal "recreational" activities are used as covers for disengagement, as in the case of "fishing" off river banks where it is guaranteed that no fish will disturb one's reverie, or "getting a tan" on the beach --activity that shields reverie or sleep although...a special uniform may have to be worn which proclaims and institutionalizes the relative inactivity (Goffman, 1963: 58).

The norm requiring that an adult in certain contexts be "involved" is unstated and unspecified in our society, but, as Goffman indicates, it exerts quite an influence over our actions. For Scheff, the most important aspect of such norms is this unspecified, yet powerful, nature. The acts of staring off into space and describing one's sexual fantasies, for example, might be wholly appropriate within some contexts and wholly inappropriate within others. The norms governing

these contexts are not easily articulated or specified. Still, we take for granted that others will act according to them. When they do not, the "unsaid" nature of the norms makes it difficult for us to categorize their violation. For instance, the man who stares off into space and describes his sexual fantasies during a session with his psychotherapist would probably be seen as reasonably "normal." The man who performs those same behaviors during his wedding ceremony is harder to categorize. Scheff suggests that, because our society provides no explicit label for the violation of such "unstated" norms, we resort to the residual catch-all category of "mental illness."

Goffman (1971) and Mechanic (1962) add that whether we see someone as "mentally ill" also depends on how we interpret their behavior. Goffman says it is often not so much the "norm violating-ness" of a behavior which makes us see someone as mentally disturbed as it is the way that violation calls into question certain fundamental beliefs:

> Even when the patient hallucinates or develops exotic beliefs, the concern of the family is not simply that a member has crazy notions, but that he is not keeping his place in relationships. Someone to whom we are closely related is someone who ought not to have beliefs which estrange him from us....The issue here is not that the family finds their home life is made unpleasant by the sick person. Perhaps most home life is unpleasant. The issue is that meaningful existence is threatened....The family members are less connected to [the patient] than they had thought (Goffman, 1971: 365-366).

This is an important distinction. Goffman is saying that whether or not a family or community member sees a behavior as "inappropriate" or "unpleasant" is often less crucial in their decision to see someone as "mentally ill" than their belief that the behavior calls fundamental ties into question. These ties connect the actor and the person observing and judging his act: "He is like me," "He finds joy in the same things I do," and so on. It is one thing for us to be disturbed by someone's behavior and quite another thing to have that behavior make us question whether fundamental ties still link us to that person. Once that sort of questioning begins, Goffman says, we are more likely to see that person as mentally ill.

In a very similar vein, Mechanic (1962) suggests that when family and community members are confronted with norm-violating behaviors they "assume the role" of the violator and attempt to understand the motives behind his behavior. If they are not able to do so, they are likely to see the norm violator's behavior as a "symptom" of mental illness. Although Mechanic does not explain this process fully, he seems to have in mind something similar to what Goffman describes: the family or community members, unable to realistically imagine the other's motives, begin to view that person as fundamentally different.

The arguments Goffman, Scheff, and Mechanic make contain a common thread: whether a behavior is seen as a "mental

symptom" or not depends upon the social context in which it occurs. A lay diagnosis of mental illness, however, does not spring neatly from every miscombination of context and act. Although such a combination may plant the seed, there is no guarantee that a diagnosis of mental illness will ever come about (Scheff, 1966: 31-32, 41-47; Goffman, 1963: 240). Such diagnoses, when they do occur, are usually an outcome of negotiations within the situation itself (Aday, 1990: 12-17, 141).

NEGOTIATIONS WITHIN SOCIAL CONTEXT

The path-breaking work in this area was that done by Yarrow and her colleagues (1955) on the processes through which wives of mentally ill men first came to define their husband's behaviors as symptoms of mental illness. At first, various behaviors and episodes violated the wives' expectations and did not seem readily understandable. The wives, however, did not immediately conclude that the behaviors were evidence of mental illness or even that they were problematic. The shift toward such conclusions resulted from an eventual "piling up" of such events rather than from a single strange or bizarre episode. Yarrow and her colleagues maintain that the wives found it personally threatening to recognize mental illness in their spouses and, therefore, tried brushing away that explanation with a variety of defenses. Some "normalized" the behavior by

pointing out instances when others performed such acts; some "attenuated" the seriousness of the behavior by finding explanations other than mental illness; some "balanced" the situation by finding normal episodes to cancel out the abnormal ones; and some simply "denied" the legitimacy of mental illness as an explanation.

Following in Yarrow's footsteps, a recent work by Whitt and Meile (1985) specifies those factors which seem to influence how "problematic" and "threatening" a decision-maker finds such situations: (a) the physical reality of the symptoms, (b) the need to account for them, (c) the need to deal with the symptoms in a way which minimizes personal costs, and (d) the number of alternative explanations available (1985: 684). The influence and interaction of these factors are evident in the phenomenon Whitt and Meile call "magnification" (1985: 690-692). Simply, the closer the decision-maker's relationship with the symptomatic person, the more likely it is he will find that person's behavior problematic. This does not mean, however, that the decision-maker will see that problem in terms of mental illness. On the contrary, such an explanation is <u>less</u> likely due to the "personal threat" of recognizing mental illness in someone so close. As this "social distance" increases, however, both the need to account for the symptomatic behavior and the personal cost involved decrease. In such cases, it is less likely that the behavior will be seen as a problem but more likely that, in those instances

when the behavior is seen as a problem, it will also be seen as evidence of mental illness. Consider the following example:

> A young man has been mumbling to himself and masturbating openly in his home for almost a week now. His mother, Mrs. L, a divorcee in her forties, pays little attention to his behavior, hoping that ignoring it will convince her son to stop. Over the past week, however, Mrs. L has begun a relationship with a man from across town. Last night, as they were parting company, this man asked if he could meet her son. She replied that her son was ill and could not have visitors for a while. What can she say the next time he asks? What if he should meet her son and find him masturbating and mumbling to himself? Would he think less of her? Would he be likely to end their relationship? What should she do?

Now, consider this same situation from another person's viewpoint --a neighbor's.

> Mrs. K, a neighbor of Mrs. L's, has heard some strange rumors about Mrs. L's son. The rumors, as told by the children who attempted to visit with Mrs. L's son and were turned away by Mrs. L, say the boy has just been walking around the house and masturbating and mumbling to himself for almost a week now.

What are the different ways these women are likely to characterize and respond to this situation? Whitt and Meile would suggest that Mrs. L is more likely to find her son's behavior problematic and personally threatening than is Mrs. K because she is faced with both the physical reality of his behaviors and a need to account for them. However, they

would also suggest that Mrs. L is less likely to see the "problem" as evidence of mental illness than is Mrs. K because such a definition would be "personally threatening."

Works by Emerson and Messinger (1977) and Sampson and his associates (1964) suggest something similar. The decision-maker these authors portray, however, is less caught up in the type of hedonistic calculus Whitt and Meile describe than he is in continuing attempts to find a strategy which works:

> A difficulty arises, a remedy is sought and applied; it works temporarily or not at all; then some new remedy is sought. The result tends to be a recurring cycle or trouble, remedy, failure, more trouble, and new remedy, until the trouble stops or the troubled person forsakes further efforts. As a consequence of these processes, the trouble is progressively elaborated, analyzed, and specified as to type and cause (Emerson and Messinger, 1977: 122).

The distinction is a fine one: whereas Yarrow and her colleagues and Whitt and Meile suggest the decision-maker's primary criterion is personal interest --what "works" in terms of his personal goals and motives, these other authors suggest the decision-maker's criteria may be more elusive and his decision-making less rational.

This notion echoes March and Simon's (1958) understanding that many --perhaps even most --decisions are made under less than ideal circumstances and in less than ideal ways. Few of the decisions we make, they say, are fully rational, take into account all the pertinent

information, or aim for optimal results. Instead, we gather the information most easily available, dispense with careful reasoning, and hope the results of our decision will "get us by" with few problems. This sort of strategy --what March and Simon call "satisficing" --seems the essence of much family and community decision-making, including that concerning mental illness.

Seen in this light, the request Mrs. L's boyfriend makes of her is one that renders her previous "satisficing" strategy (ignoring the behavior and hoping it will stop) unsatisfactory. The same event, meanwhile, means nothing to Mrs. K's relationship with Mrs. L's son because whatever "satisficing" strategy she may have taken toward the boy (keeping her children away, complaining to neighbors) remains "satisficing."

Given this change, Mrs. L may seek to "re-satisfice" her situation by defining her son's problem as mental illness and treating it as such, but this is not necessarily the first or only strategy she may consider. Instead, as March and Simon point out, the direction of such steps is usually determined by whatever information and resources the decision-maker has available. For instance, Mrs. L's decision may or may not be informed by ideas concerning mental illness and its treatment and, even if it is, she may not choose that strategy for reasons of resources (perhaps she lacks the necessary funds or perhaps her decision is swayed by a chance to have the boy stay with other family

members). In any event, she will pick --usually under the less-than-ideal circumstances and in the less-than-ideal ways March and Simon describe --the strategy that seems most likely to "satisfice" her situation. She will then stay with that strategy until her situation changes and the strategy no longer "satisfices." For instance, Mrs. L may place her son in a mental hospital and realize, after visiting him a few times, that he is very unhappy there. If his happiness figures heavily among her few "satisficing" criteria, she may decide that hospitalization --despite the benefits it may have for her new romance --will not "satisfice." She would then seek yet another strategy. In the end (if, indeed, Mrs. L's search for a "satisficing" strategy ever ends), whether her son is seen as "mentally ill" or "mentally healthy" or something else will be an outcome negotiated over the course of this process.

Overall, these pieces of research suggest two distinct causal relationships within this negotiating process:

> (1) The closer the relationship between the decision-maker and the symptomatic person, the more likely it is the decision-maker will find the symptomatic person's behavior problematic and threatening and the less likely it is he will see that behavior as evidence of mental illness.
>
> (2) Events occurring outside the relationship between decision-maker and symptomatic person may "de-satisfice" the decision-maker's strategy for dealing with the problems presented by that relationship. Because of this effect, the decision-maker may turn to

strategies based on concepts of mental illness.

THE RESEARCH PROBLEM

Although the processes and outcomes suggested by this previous research seem to make sense, they have not been the subject of systematic study. The research presented here represents an attempt to correct that situation. The general questions behind this research are simple:

> (1) Is it true that family members are more likely than others to find symptomatic behavior problematic and threatening?
>
> (2) Is it true that family members are less likely than others to see such behaviors as evidence of mental illness?
>
> (3) Is it true that disrupting --or "de-satisficing" events --impact the relationship between decision-maker and symptomatic person in such a way as to make more likely a coping strategy based on concepts of mental illness?

THE RESEARCH METHODOLOGY

Although previous research usually involved field work or examination of official records, neither of those methodologies was chosen for this research. Such methods bring us closer to "real life" than other methods might, but by doing so they plunge us into a realm in which confounding variables abound and experimental control is nearly impossible. For instance, the researcher might encounter conflicting records and testimonies (Emerson and Messinger,

1977: 125) or ones colored by the help-seeking acts or diagnoses themselves (Scheff, 1966). He may hear dozens of conflicting accounts as to how and why and when certain decisions occurred and be unable to determine the verity of any --except, perhaps, through extensive (and, thus, ethically troubling) cross-examination.

One major difficulty with suggestions from the previous research is that they often spring from such swamps of causality. Recall, for example, Yarrow's suggestion that the wives' denial was motivated by "personal threat." Nowhere do Yarrow and her colleagues provide evidence for this point. Instead, it is an interpretation based on the fact that the subjects were involved in close personal relationships (Yarrow, 1955: 23). While Yarrow's suggestion is reasonable, it is perhaps just as likely that the wives' reluctance to embrace a "mental illness" explanation arose from other factors present in their situations --ones that Yarrow and her colleagues simply disregard.

The task of my methodology was to avoid such confounding variables while addressing the research issues squarely. Scenario-based research, with its capacity for creating controlled analogs of "real life" situations, seemed to provide a way of doing that. In order to use the method effectively, however, my scenarios would have to be very different from ones used in the past (see Star, 1955; Phillips, 1962, 1963). For example, instead of casting the reader as a passive observer, the scenarios would have to

draw him into the situation as an active decision-maker. And, instead of simply presenting a list of symptoms, they would have to detail an evocative and believable situation.

At the same time, the scenarios would have to control key factors that might obscure the effects of the experimental variables. Such factors (symptoms, behaviors, circumstances, and so on) would have to be identical or very similar in each scenario. Only the independent variables themselves --the closeness of the decision-maker, the presence or absense of a "de-satisficing" event --could differ significantly from one scenario to another. Attempts would have to be made also to manage confounding factors not managed within the scenarios themselves. These attempts would have to focus, especially, on those factors most likely to impact the dependent variables. The methodology focused on two particular factors of this sort, the first indicated by previous reseach and the second indicated by the author's experience: (a) individual differences in backgrounds and values, and (b) familiarity with mental illness and mental illness treatment.

The research was designed and carried out with these considerations in mind. Eighty-six volunteers were asked to assume a role --"family" or "non-family" --while reading a fictional case study that included that role (see Appendix A for annotated samples of these). Each scenario described the volunteer's relationship with "John," a thirteen year old boy. In the "family" condition, the volunteer's role was

that of a college-age sibling caring for John during an extended parental absense. In the "non-family" condition, the role was that of a college-age neighbor called in to baby-sit during a similar absense. In both conditions, John was described as manifesting behaviors that could be interpreted as symptoms of mental illness: social withdrawal, talking to himself, and occasional violent outbursts. In half of the scenarios for each condition, a potentially "de-satisficing" event was introduced. In both the family and non-family conditions, this event involved a new romantic interest for the decision-maker: someone who might be troubled by John's behavior. In the other half this event was absent.

Table 1. Research design in four-celled format.

"de-satisficing" event is present?	closeness of relationship between decision-maker and symptomatic person: family:	non-family:
yes:	condition 1	condition 2
no:	condition 3	condition 4

This design involves two independent variables and three dependent variables. The two independent variables

(closeness of relationship between decision-maker and symptomatic person, presence or absense of a "de-satisficing" event) were manipulated to create four scenarios and, thus, four distinct experimental conditions: (1) "family" responds to "event present," (2) "non-family" responds to "event present," (3) "family" responds to "event absent," and (4) "non-family" responds to "event absent" (see Table 1). The three dependent variables of concern were the respondents' characterizations of the hypothetical situation, their explanations of the situation, and their reactions to the situation. These were measured through responses to a short questionnaire which followed the scenarios. The specifics of this questionnaire are discussed more fully below.

You will note that the methodology operationalizes the "closeness" variable in terms of family or non-family status. This was done quite purposefully. In the literature (especially Whitt and Meile, 1985) these concepts are used quite loosely and almost interchangeably. What these authors have in mind when they talk about a "close" relationship is unclear, but they are clear on one point: that a family relationship captures its essence. My best interpretation of the concept of "closeness" is this: a close relationship is one in which one's interests are highly impacted by the actions and well-being of another. The scenarios were designed to reflect both this interpretation and the literature's typification of a "close" relationship as a family one.

The research design allowed control over confounding variables as follows. First, to keep effects from individual differences in backgrounds and values to a minimum, the volunteers were drawn from the College's rather homogeneous pool of undergraduate students. Then, to allow for the examination of effects from prior experience with mental illness, the volunteers were asked questions regarding their familiarity with mental illness and its treatment. Each volunteer was then ranked on a scale of "low," "moderate," and "high" familiarity.

Despite the advantages afforded through the use of scenarios, the methodology presented some problems and limitations:

(1) The problem of "responding in character." Although each question reminded the volunteer to answer as if he or she were "the person whose situation is described in the scenario," there was no way to ensure that the volunteers did so or that they did so consistently.

(2) The problem of hypothetical situations. It may be that, even if the volunteers did answer "in character," the scenarios lacked the immediacy and urgency necessary to elicit responses truly representative of "real life" situations.

(3) The problem of similar situations. Even though the "family" and "non-family" scenarios were designed to be as similar as possible, subtle differences may have remained.

GENERAL FINDINGS FROM THE RESEARCH

As just described, the research employed two independent variables (the closeness of the decision maker, the presence or absence of a possibly "de-satisficing" event), one control variable (familiarity with mental illness and its treatment), and three dependent variables (characterizations of the situation, explanations of the situation, responses to the situation). To determine if the independent variables impacted the dependent variables in any significant way, the results for each independent variable were examined under four conditions: (1) with "familiarity" controlled, (2) with the other independent variable controlled, (3) with "familiarity" and the other independent variable controlled, and (4) with neither "familiarity" nor the other independent variable controlled. Although both of the independent variables were expected to have an significant impact on the dependent variables, only the "closeness" variable did. This failure on the part of the "event" variable suggests that the methodology did not portray that variable believably enough. "Familiarity," meanwhile, appeared to play a limited role in modifying the effects of "closeness." The findings below are presented in terms of those independent and control variables for which the data seem reasonably valid: (1) the closeness of the relationship between the decision-maker and the symptomatic person, and (2) the decision-maker's familiarity with mental illness. Findings for the "event" variable are presented in Appendix B.

RESPONDENTS' CHARACTERIZATIONS OF THE SITUATION

In the first section of the survey, the volunteers were asked to characterize the situation described in the scenario. There were seven questions: (1) "Do you find the situation problematic?" (2) "Do you find the situation worrisome?" (3) "Do you find the situation threatening?" (4) "Do you find the situation challenging?" (5) "Do you find the situation annoying?" (6) "Do you find the situation embarrassing?" and (7) "Do you find the situation frightening?" Three answers were available for each: "no," "somewhat," or "yes."

Although previous research suggests that, with other factors held constant, family should find symptomatic behavior more "problematic" and "threatening" than non-family, no significant differences of those sorts were found in the current study (see Tables 2 and 3).

Table 2. Family and non-family responses to the question "Do you find the situation problematic?"

	FAMILY	NON-FAMILY
"no"	2.3%	2.4%
"somewhat"	13.6%	16.7%
"yes"	84.1%	81.0%
	(N=44)	(N=42)

Table 3. Family and non-family responses to the question "Do you find the situation threatening?"

	FAMILY	NON-FAMILY
"no"	20.5%	19.0%
"somewhat"	56.8%	59.5%
"yes"	22.7%	21.4%
	(N=44)	(N=42)

Instead, the groups varied on other measures. For instance, although very few family and non-family respondents found the situation "embarrassing," significantly more family than non-family respondents found it so (see Table 4). Among those relatively unfamiliar with mental illness and its treatment this difference was even greater (see Table 5). While the majority of low familiarity non-family respondents did not find the situation embarrassing (85 percent), the majority (56.3 percent) of low familiarity family respondents described it as "somewhat embarrassing" or "embarrassing."

A somewhat similar pattern appears in the degree to which the volunteers found the situation "annoying." The general trend was to find the situation "somewhat annoying" (see Table 6). Among those reporting high familiarity with mental illness, however, differences appear between the family and non-family groups (see Table 7). Whereas high familiarity family respondents found the situation "not

annoying" (57 percent) or "somewhat annoying" (42.9 percent), high familiarity non-family respondents found it "somewhat annoying" or "annoying" (50 percent each) --a clear and significant difference.

Table 4. Family and non-family responses to the question "Do you find the situation embarrassing?"

	FAMILY	NON-FAMILY
"no"	56.8%	73.8%
"somewhat"	31.8%	26.2%
"yes"	11.4%	0.0%
	(N=44)	(N=42)

Sig. < .05 (Chi Square)

Table 5. Among those reporting low familiarity with mental illness, family and non-family responses to the question "Do you find the situation embarrassing?"

	FAMILY	NON-FAMILY
"no"	43.8%	85.0%
"somewhat"	31.3%	15.0%
"yes"	25.0%	0.0%
	(N=16)	(N=20)

Sig. < .05 (Chi Square)

Table 6. Family and non-family responses to the question "Do you find the situation annoying?"

	FAMILY	NON-FAMILY
"no"	31.8%	23.8%
"somewhat"	54.5%	50.0%
"yes"	13.6%	26.2%
	(N=44)	(N=42)

Table 7. Among those reporting high familiarity with mental illness, family and non-family responses to the question "Do you find the situation annoying?"

	FAMILY	NON-FAMILY
"no"	57.1%	0.0%
"somewhat"	42.9%	50.0%
"yes"	0.0%	50.0%
	(N=7)	(N=6)

Sig. < .05 (Chi Square)

On the remaining measures the family and non-family groups responded very similarly and familiarity with mental illness did not have a significant impact. Respondents generally characterized the situation as "challenging," "worrisome," and somewhere between "somewhat frightening" and "frightening" (See Tables 8, 9, and 10).

Table 8. Family and non-family responses to the question "Do you find the situation challenging?"

	FAMILY	NON-FAMILY
"no"	6.8%	11.9%
"somewhat"	22.7%	33.3%
"yes"	70.5%	54.8%
	(N=44)	(N=42)

Table 9. Family and non-family responses to the question "Do you find the situation worrisome?"

	FAMILY	NON-FAMILY
"no"	2.3%	2.4%
"somewhat"	13.6%	14.3%
"yes"	84.1%	83.3%
	(N=44)	(N=42)

Table 10. Family and non-family responses to the question "Do you find the situation frightening?"

	FAMILY	NON-FAMILY
"no"	15.9%	4.8%
"somewhat"	36.4%	50.0%
"yes"	47.7%	45.2%
	(N=44)	(N=42)

RESPONDENTS' EXPLANATIONS OF THE SITUATION

The previous research leads us to expect that, with all other factors held equal, family are less likely than non-family to choose a "mental illness" explanation. To see if this was true in the survey groups, the volunteers were presented with four possible explanations for the hypothetical situation: mental illness, physical illness, stress, and personal conflict. These were presented in pairs, each paired against the other, and the volunteers were asked to choose the "most likely" explanation from each pair (see Appendix C for the format of this question). Answers were recorded such that relative likelihood of the "mental illness" explanation would result in a score of three (as it was chosen over each of the other options) and relative unlikelihood would result in lower scores (as the "mental illness" explanation lost out to the other options one or more times).

With this in mind, the scores for the "mental illness"

explanation are interesting (see Table 11). Among both family and non-family the most common score was one, indicating low likelihood for the "mental illness" explanation. The distribution of higher scores was mixed. Scores of two, indicating a slightly higher likelihood for the "mental illness" explanation, were more common among non-family than family. Scores of three (indicating very high likelihood), however, were more common among family than non-family. These mixed patterns persisted even when the volunteers' familiarity with mental illness was controlled (see Table 12).

Table 11. Family and non-family scores for explanation of the situation.

	FAMILY	NON-FAMILY
0: least likely mental illness	0.0%	4.8%
1:	47.7%	50.0%
2:	18.2%	28.6%
3: most likely mental illness	34.1%	16.7%
	(N=44)	(N=42)

Table 12. Family and non-family scores for explanation of the situation, controlling for familiarity with mental illness.

	low familiarity	
	FAMILY	NON-FAMILY
0: least likely mental illness	0.0%	5.0%
1:	62.5%	55.0%
2:	18.8%	30.0%
3: most likely mental illness	18.8%	10.0%
	(N=16)	(N=20)

	moderate familiarity	
	FAMILY	NON-FAMILY
0: least likely mental illness	0.0%	0.0%
1:	47.6%	53.6%
2:	9.5%	18.8%
3: most likely mental illness	42.9%	25.0%
	(N=21)	(N=16)

	high familiarity FAMILY	NON-FAMILY
0: least likely mental illness	0.0%	16.7%
1:	14.3%	16.7%
2:	42.9%	50.0%
3: most likely mental illness	42.9%	16.7%
	(N=7)	(N=6)

RESPONDENTS' REACTIONS TO THE SITUATION

In the final part of the survey, the volunteers were given a list of seven possible strategies they might pursue in response to their hypothetical situations. They then were asked to pick the three most likely strategies and rank them in order of descending likelihood. In each case, these were scored one through three --one for the least likely of the three and three for the most likely. The four neglected strategies all were scored zero.

For both family and non-family, four strategies were very unlikely: taking John to a hospital, taking him to a mental hospital, taking him to a physician, and calling the police (Tables 13-16). A fifth strategy, taking John to a counselor, was likely for both groups (Table 17). Opinions on the final two strategies were less shared or clear-cut. Nearly half of each group, for example, listed "calling a mental health hotline" as their most likely or second most likely strategy. In both groups, however, this number was

balanced out by many for whom the "hotline" strategy never made the top three (see Table 18). Opinions on the "taking John to see a psychiatrist" strategy, meanwhile, were clearly and significantly different. Family members, not non-family members, were more likely to seek psychiatric help for John (see Table 19).

Table 13. Likelihood to take John to a hospital. Family and non-family responses.

	FAMILY	NON-FAMILY
0: unlikely	88.6%	85.7%
1:	11.4%	11.9%
2:	0.0%	2.4%
3: very likely	0.0%	0.0%
	(N=44)	(N=42)

Table 14. Likelihood to take John to a mental hospital. Family and non-family responses.

	FAMILY	NON-FAMILY
0: unlikely	86.4%	88.1%
1:	13.6%	9.5%
2:	0.0%	2.4%
3: very likely	0.0%	0.0%
	(N=44)	(N=42)

Table 15. Likelihood to take John to a physician. Family and non-family responses.

	FAMILY	NON-FAMILY
0: unlikely	56.8%	40.5%
1:	29.5%	21.4%
2:	6.8%	19.0%
3: very likely	6.8%	19.0%
	(N=44)	(N=42)

Table 16. Likelihood to call the police. Family and non-family responses.

	FAMILY	NON-FAMILY
0: unlikely	100.0%	100.0%
1:	0.0%	0.0%
2:	0.0%	0.0%
3: very likely	0.0%	0.0%
	(N=44)	(N=42)

Table 17. Likelihood to take John to a counselor. Family and non-family responses.

	FAMILY	NON-FAMILY
0: unlikely	11.4%	14.3%
1:	0.0%	7.1%
2:	22.7%	33.3%
3: very likely	65.9%	45.2%
	(N=44)	(N=42)

Table 18. Likelihood to call a mental health hotline. Family and non-family responses.

	FAMILY	NON-FAMILY
0: unlikely	40.9%	28.6%
1:	18.2%	19.0%
2:	22.7%	21.4%
3: very likely	18.2%	31.0%
	(N=44)	(N=42)

Table 19. Likelihood to take John to a psychiatrist. Family and non-family responses.

	FAMILY	NON-FAMILY
0: unlikely	15.9%	42.9%
1:	27.3%	31.0%
2:	47.7%	21.4%
3: very likely	9.1%	4.8%
	(N=44)	(N=42)

Sig. < .05 (Chi Square)

DISCUSSION

Recall that the "de-satisficing" events written into the scenarios involved a new romance for the decision-maker --a romance with someone who might be frightened away by John's behavior. The aim of these events was, simply, to thoroughly "de-satisfice" the decision-maker's current strategy toward John so that he or she would have to find a new one. The interest was whether the strategies chosen by decision-makers in "de-satisficed" situations differed significantly from those chosen by decision-makers in more "satisficed" situations. The results, as we have seen (again, see Appendix B), indicate no significant differences between these groups. For this two interpretations seem possible. The first would suggest that, contrary to suggestions from

the previous research, such events have little or no impact on relationships between decision-makers and symptomatic persons. The second would suggest that the particular "de-satisficing" events employed in the research might not have "de-satisficed" in the way they were intended.

This second interpretation seems more likely. As mentioned before, the scenario format presents certain limitations. The greatest of these is its inability to create meaningful analogs of certain social phenomena. It is one thing to imagine oneself as a baby sitter or family member confronted with odd behavior. It is probably a very different and more difficult thing to realistically imagine how one would act when gripped by fear and love and guilt. This research required such a task. The results seem to indicate that meaningful analogs of such surging emotions are somewhat beyond the capabilities of simple scenarios. This does not mean that any attempts to create analogs of "de-satisficing" events are doomed to failure. It may well be that other methods will work or that scenarios can create meaningful analogs of less emotional "de-satisficing" events.

As heartening as these possibilities may be, they do not alleviate the current difficulty. Recall that the research problem, as originally stated, concerned two independent variables: (1) closeness of the relationship between decision-maker and symptomatic person and (2) presence or absense of a "de-satisficing" event. Questions regarding the validity of our "de-satisficing" variable now push half of

that problem temporarily beyond our reach. Our chance to examine suggestions from the previous research on the effects of "de-satisficing" events, then, is delayed, and the range of our discussion narrows considerably.

Given this difficulty, might it not be that other elements of the scenarios also failed to create the kinds of conditions they were designed to create? Perhaps. Recall, however, that the research attempted to create controlled analogs, not exact duplicates, of certain "real-life" decision-making situations and processes. Although these analogs may have failed to approximate some "real life" conditions (the impact of "de-satisficing" events), they seem to have successfully approximated others (the "family"/"non-family" distinction). It is in the light and limitations of that success that the following observations are made.

First, the findings suggest that, although the family of a symptomatic person may indeed find that person's behavior "problematic" or "threatening," non-family persons may find it equally so. Although this seems to rub directly against suggestions from the previous research, it need not do so. Instead, it may be (as I suggested before) that Yarrow (1955) and others have mistaken the effects of the family <u>situation</u> for the effects of the family <u>relationship</u>. In other words, they may have mistaken the effects of "living with a person" for the effects of "being related to a person."

Second, this is not to suggest that, given identical

situations, family and non-family will perceive things identically. Indeed, as we saw on the scores for "embarrassment" and "annoyance," similar circumstances do not necessarily make for similar descriptions. These same differences also suggest that it may be simplistic and misleading to speak (as Whitt and Meile, 1985, and others do) as if "problems" exist in discrete and generic units that can be stacked up and measured against one another. When a careful understanding is necessary, a more fruitful approach might be to drop the generic "problems" line of inquiry and pursue the various types of problems involved: embarassment, annoyance, fear, and so on.

Third, these findings also suggest that familiarity with mental illness and its treatment plays a key role in these negotiations. At very low and very high levels of familiarity, for instance, family and non-family sometimes had very different perceptions of the same situation. At low levels, family were much more embarassed by the situation than were non-family. At high levels, meanwhile, non-family were much more annoyed than were family. These findings suggest that familiarity with mental illness may play a crucial role in how symptoms are perceived, that it may decrease the embarassment felt by family members, and that it may increase the annoyance others feel toward a symptomatic person. The previous research has ignored this variable. In future research it must be taken into account.

Fourth, the results suggest that family may not be less

likely than non-family to explain the behavior of a symptomatic person in terms of "mental illness." The results on this topic, you may recall, were mixed. Neither family nor non-family seemed likely to use the "mental illness" explanation for John's behavior. Similarly, both groups shied away from the "mental hospital" strategy and were ambivalent about the "mental health hotline" strategy. Family, however, were more likely than non-family to take John to a psychiatrist. Taken together, these results suggest that although both family and non-family avoided the "mental illness" explanation, family were somewhat more likely to make decisions that could lead to such an explanation.

To suggest that "closeness" plays a role in this way, however, is a far cry from accepting Yarrow's (1955) notion of "personal threat" as the motivating factor in these negotiations. Instead, it suggests that other factors associated with close personal relationships --responsibilities, obligations, and so on --may also play important roles in such negotiations. The non-family decision-makers, for instance, may have felt that certain decisions, such as deciding whether John should be exposed to a system that might label him "mentally ill," lay outside their responsibilities. The family decision-makers, meanwhile, while perhaps equally uncomfortable with such decisions, may have felt more responsible and, thus, more compelled to make them.

SUMMARY AND CONCLUSIONS

It seems, then, that although Yarrow's work (along with its echoes and refinements in the work of Whitt and Meile and others) is helpful, its focus on personal interest may be too narrow. Yarrow (1955) and others after her have proposed a simple causal relationship. While this simplicity makes their arguments very easy to understand and cite, it may also rob them of their robustness.

It may be that the more complex "satisficing" model suggested by March and Simon (1958; echoed, perhaps unwittingly, in Emerson and Messinger, 1977, and Sampson et al, 1964) provides a more accurate understanding of these negotiations. It is unfortunate that the part of this research specifically aimed at examining that model failed to result in reliable data. It leaves us in the uncomfortable position of having data with which to point out problems but without which to point out possible solutions.

Obviously, this paper is not the final word on these subjects. Instead, I hope it might serve as a "first" word, a jump-start to a stalled conversation. For nearly three decades, research on the negotiations which lead to lay diagnoses of mental illness have been nearly unanimous on one point: the family of a symptomatic person are more likely than others to find that person's behavior problematic but, due to the "personal threat" involved in recognizing mental illness in someone so close, they are less likely than others

to see that behavior as evidence of mental illness. The findings from the present research suggest, simply, that this may not be so. My aim in saying this is not to question the validity of the previous research. Limitations imposed by sample size and methodology alone would make any such statements problematic. My aim, instead, is to suggest that the matter may not be as neatly resolved as some have suggested.

SUGGESTIONS FOR FURTHER RESEARCH

Throughout this work I have pointed out methodological and theoretical problems in the previous research and in my own research. Along the way I have also made suggestions as to how these difficulties might be avoided or corrected. Here I would like to make some final suggestions of that sort so that future research in this vein might be more fruitful.

Researchers interested in pursuing the methodology employed here should consider using samples from other populations to see if the outcomes suggested by the previous research are more or less true among those groups. These researchers might also consider employing scenarios featuring different "symptoms" to discover whether patterns differ significantly in response to different behaviors.

Researchers interested in refining the methodology should look into making the scenarios more dynamic and life-like. One approach might be to make them longer and

more involved. Another approach might be to abandon the written format for active role-plays in which subjects interact with a person trained to portray mental illness.

Appendix A: Sample scenarios.

This first scenario was used in the "family" conditions. Paragraphs 1-5 detail the volunteer's "relationship" with the symptomatic person, present the symptomatic behavior, describe past strategies, and place the volunteer in a decision-making situation. A scenario consisting of only these paragraphs fits experimental condition 3 ("family" responds to "event absent"). When paragraph 6, which introduces a potentially "de-satisficing" event, is added, the scenario fits experimental condition 1 ("family" responds to "event present").

A year ago your father's job required a temporary (two year) move overseas and, although he and your mother had hoped you would join them, they understood when you and your 13 year-old brother, John, decided to stay. After all, both of you had just settled into school (you in college; your brother in junior high) and it seemed a shame to pull you out just as you were making friends and becoming comfortable there. Your parents also were persuaded by the responsibility you had always demonstrated --and by your promise to take care of and watch over your brother until the overseas assignment ended and they returned.

Before your parents moved, they found you and your brother a townhouse and set up a fund from which you could draw money for tuition, rent, food, and other major expenses. Other everyday living expenses, they explained, would have to come from your part-time job.

This year has brought a lot of changes: You and your brother have grown up a lot, and you have also grown much closer, sharing good times and seeing each other through the bad ones as you never had before. In recent weeks, however, John's behavior has begun to worry you. You and he used to spend a lot of time together in the evenings, but lately he's become very withdrawn. Quite often, by the time you come home from work and classes, he's already eaten dinner and shut himself away in his room. When you knock on his door he rarely comes out. Instead, he usually stays in there listening to the radio and talking to himself. At first you thought he may have been talking to school friends on the telephone, but the line's always clear when you check.

When you have seen John, his behavior has been very unpredictable. Usually he's very quiet, but on a few occasions, he's exploded in a rage over tiny things. Once he even ran to the kitchen, pulled out a knife, and started

slashing the living room curtains to bits. This sort of behavior seems so out-of-character. Just a month or so ago you were thinking you knew your brother better than anyone, but now you're not so sure.

So far you've dealt with John's behavior in a couple of ways. You tried and gave up on the "let's talk about it" approach because it just seemed to make him more withdrawn. Lately your efforts have been less forward. When you're watching TV at night you'll sometimes yell upstairs that something really good is on, or you'll laugh loudly, hoping he'll become intrigued and come down to see what's on. You'd hoped that maybe that would bring you together and give you something to talk about --something that might lead to a discussion of what's <u>really</u> going on. So far, though, those strategies haven't worked as often or as well as you'd hoped they would.

And there's something else: Recently, during classes and over a few lunch and dinner dates, you've been getting to know a girl whose company you enjoy. She's made no secret of the fact that she feels similarly about you. This is a welcome relief from your day-to-day concerns and studies. You don't want to rush this new relationship, but you don't want to blow it either. Your dates so far have involved meals or movies "out" or over at her place, but lately she's been hinting that you two should spend an evening at your place. You tried to turn her off the idea by telling her that you live with your younger brother, but that didn't work. She said she'd be "happy" to meet him and that she was looking forward to "getting to know" him. What you fear is that this girl might come over, find John talking to himself or ripping up the curtains, get scared, and stop being interested in you. One way around this might be to never let her come over and meet your brother, but you're afraid that will just drive her away also --that she may interpret your reluctance as a sign of distrust or disinterest.

Appendix A: Sample scenarios, continued.

This second scenario was used in the "non-family" conditions. Paragraphs 1-3 detail the volunteer's "relationship" with the symptomatic person, present the symptomatic behavior, describe past strategies, and place the volunteer in a decision-making situation. A scenario consisting of only these paragraphs fits experimental condition 4 ("non-family" responds to "event absent"). When paragraph 4, which introduces a potentially "de-satisficing" event, is added, the scenario fits experimental condition 2 ("non-family" responds to "event present").

On occasions over the past year or two you've "babysat" John --who is now 13 --while his father and mother were away. The first time you did it as a favor (John's dad was your Biology professor at the time). You've continued because of the extra cash and quiet study time it provides. Over this time John's parents have come to trust and value your judgment and responsibility --so much so that they often won't go out unless you are available to sit. In the past their longest trips lasted only a couple of days. During those times you would stay in their home and keep John company when he got home from school. The trip they just left on, however, will be significantly longer --a full month. You're being paid well and so far it has been a nice break from dormitory life, but John's behavior has begun to worry you. In the past, you and he used to spend time together in the evenings, working on homework or watching TV, but he seems very withdrawn this time. Quite often, by the time you return from classes, he's already eaten dinner and shut himself away in his room. When you knock, he rarely answers or comes out. Instead, he usually stays in there listening to the radio and talking to himself. At first you thought he may have been talking to school friends on the telephone, but the line's always clear when you check.

When you have seen John, his behavior has been very unpredicatable. Usually he's very quiet, but on a few occasions he's exploded in a rage over tiny things. Once he even ran into the kitchen, pulled out a knife, and started slashing at the living room curtains. This sort of seems out-of-character. You've been "sitting" with John for a while now and thought you knew him pretty well, but now you're not so sure.

So far you've dealt with John's behavior in a couple of ways. You tried and gave up on the "let's talk about it"

approach because it just seemed to make him more withdrawn. Lately your efforts have been less forward. When you're watching TV at night you'll sometimes shout upstairs that something really good is on, or you'll laugh loudly, hoping John will come down to see what's on. You hoped that sort of strategy might lead to a discussion of what's wrong, but so far it hasn't worked as often or as well as you'd hoped it would.

And there's something else. During classes you've been getting to know a girl whose company you enjoy. She's made no secret of the fact that she feels similarly about you. This is a welcome relief from your day-to-day concerns and studies. You don't want to rush this new relationship, but you don't want to blow it either. Last week you told this girl about how you'd be "sitting" with John and how it might be fun for the three of you to spend some time time together --kind of a prelude to real "dating." Now you're wondering if that would be a good idea after all. What you fear is that this girl might come over, find John talking to himself or ripping up the curtains, get scared, and stop being interested in you. One way around this might be to never let her come over, but you're afraid that will just drive her away also --that she may interpret your reluctance as a sign of distrust or disinterest.

Appendix B: Results for the "de-satisficing" event variable. Responses for "event present" and "event absent" conditions.

Table a. Responses to the question "Do you find the situation problematic?"

	PRESENT	ABSENT
"no"	2.3%	2.4%
"somewhat"	22.7%	7.1%
"yes"	75.0%	90.5%
	(N=44)	(N=42)

Table b. Responses to the question "Do you find the situation threatening?"

	PRESENT	ABSENT
"no"	20.5%	19.0%
"somewhat"	54.5%	61.9%
"yes"	25.0%	19.0%
	(N=44)	(N=42)

Table c. Responses to the question "Do you find the situation embarrassing?"

	PRESENT	ABSENT
"no"	65.9%	76.2%
"somewhat"	29.5%	16.7%
"yes"	4.5%	7.1%
	(N=44)	(N=42)

Table d. Responses to the question "Do you find the situation annoying?"

	PRESENT	ABSENT
"no"	31.8%	23.8%
"somewhat"	50.0%	54.8%
"yes"	18.2%	21.4%
	(N=44)	(N=42)

Table e. Responses to the question "Do you find the situation challenging?"

	PRESENT	ABSENT
"no"	13.6%	4.8%
"somewhat"	34.1%	21.4%
"yes"	52.3%	73.8%
	(N=44)	(N=42)

Table f. Responses to the question "Do you find the situation worrisome?"

	PRESENT	ABSENT
"no"	4.5%	0.0%
"somewhat"	18.2%	9.5%
"yes"	77.3%	90.5%
	(N=44)	(N=42)

Table g. Responses to the question "Do you find the situation frightening?"

	PRESENT	ABSENT
"no"	13.6%	7.1%
"somewhat"	40.9%	45.2%
"yes"	45.5%	47.6%
	(N=44)	(N=42)

Table h. Scores for explanation of the situation.

	PRESENT	ABSENT
0: least likely mental illness	2.3%	2.4%
1:	54.5%	42.9%
2:	22.7%	23.8%
3: most likely mental illness	20.5%	31.0%
	(N=44)	(N=42)

Table i. Likelihood to take John to a hospital.

	PRESENT	ABSENT
0: unlikely	90.9%	83.3%
1:	9.1%	14.3%
2:	0.0%	2.4%
3: very likely	0.0%	0.0%
	(N=44)	(N=42)

Table j. Likelihood to take John to a mental hospital.

	PRESENT	ABSENT
0: unlikely	88.6%	85.7%
1:	11.4%	11.9%
2:	0.0%	2.4%
3: very likely	0.0%	0.0%
	(N=44)	(N=42)

Table k. Likelihood to take John to a physician.

	PRESENT	ABSENT
0: unlikely	47.7%	50.0%
1:	27.3%	23.8%
2:	15.9%	9.5%
3: very likely	9.1%	16.7%
	(N=44)	(N=42)

Table l. Likelihood to call the police.

	PRESENT	ABSENT
0: unlikely	100.0%	100.0%
1:	0.0%	0.0%
2:	0.0%	0.0%
3: very likely	0.0%	0.0%
	(N=44)	(N=42)

Table m. Likelihood to take John to a counselor.

	PRESENT	ABSENT
0: unlikely	13.6%	11.9%
1:	2.3%	4.8%
2:	25.0%	31.0%
3: very likely	59.1%	52.4%
	(N=44)	(N=42)

Table n. Likelihood to call a mental health hotline.

	PRESENT	ABSENT
0: unlikely	34.1%	35.7%
1:	25.0%	11.9%
2:	18.2%	26.2%
3: very likely	22.7%	26.2%
	(N=44)	(N=42)

Table o. Likelihood to take John to a psychiatrist.

	PRESENT	ABSENT
0: unlikely	25.0%	33.3%
1:	25.0%	33.3%
2:	40.9%	28.6%
3: very likely	9.1%	4.8%
	(N=44)	(N=42)

Appendix C: Format of the "explanation" section from the survey

Below are some terms that might be used to explain the problems encountered in the scenario. They are presented in pairs so that you must choose which is the better of the two. Take the pairs one at a time and weigh the explanations, comparing only within the pairs.

If you were the person in the situation described, how would you explain the problems encountered? Are the problems more likely the result of...

a. physical illness or mental illness?

[ ] physical illness [ ] mental illness

b. mental illness or stress?

[ ] mental illness [ ] stress

c. stress or personal conflict?

[ ] stress [ ] personal conflict

d. personal conflict or physical illness?

[ ] personal conflict [ ] physical illness

e. physical illness or stress?

[ ] physical illness [ ] stress

f. personal conflict or mental illness?

[ ] personal conflict [ ] mental illness

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