THE DETERMINATION OF COMMUNITY ATTITUDES TO MENTAL ILLNESS

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November 1967.

SUMMARY

The first part of this study consists of a review of the literature on the determination of community attitudes to mental illness. Beginning with theoretical and sociological considerations, the subject is pursued through the involvement of special groups of health workers, to the viewpoint of close relatives and eventually to the community at large.

The study next proceeds to describe the aims, organisation and results of a survey carried out in a random sample of the adult Edinburgh population in the summer of 1966. Three hundred and seventy-three persons were interviewed in their homes, using a pre-tested structured questionnaire. The interview covered demographic data, personal familiarity with mental illness through close experience or information, and a range of attitudes and opinions regarding mental illness and the mentally ill.

The results show that the Edinburgh population are generally familiar with this topic and prepared to discuss it frankly. Although many traces of old stereotypes of mental illness still remain and whilst the public has not yet completely adopted the prevailing psychiatric viewpoint, there is evidence of relatively greater sympathy and tolerance among the younger and better educated sections of the community. This may mean that still further acceptance of psychiatric diagnoses and treatments is to be anticipated in the future.

At the same time personality factors, such as neuroticism and a high/

high regard for self-reliance, are also involved in the extent of sympathy and tolerance which people feel towards the mentally ill.

The picture of mental illness as projected by the mass media in Britain seems to be educating rather than alarming the public, but there is still room for improvement in certain specific directions.

The changing public view of mental illness may well pose problems of accommodation and adaptation for the psychiatric services and medical personnel.

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INTRODUCTION

The understanding and assessment of community attitudes to mental illness and the mentally ill has recently assumed great importance in view of the implications of the Mental Health Act (1959) with its emphasis on informal admission procedures and the anticipated maintainance of many ex-mental patients in the community.

At the same time, new developments in therapeutics have made possible the treatment at home of many people who would formerly have been condemned to prolonged institutional care.

Both the successful implementation of the humane provisions in the Act and the outcome of home therapy will depend in part upon the response of society to the new provisions and the new treatment.

Secondly, community attitudes carry clear implications for the epidemiology of mental illness. The number of cases of mental illness diagnosed as such by psychiatrists is not only closely related to the definitions of illness assumed by those persons who are presently to be regarded as patients, but also to the definitions and attitudes of their friends, their relations and their doctors.

Finally/

Finally, if it should be considered desirable to embark upon programmes of health education in an effort to modify public attitudes and opinions regarding this subject, some estimate of the existing level of information in the target population would be a necessary base for any propaganda.

The following study will review some of the literature relating to community attitudes to mental illness and the mentally ill, beginning with more general references and proceeding to individual special studies of the attitudes of particular groups and of samples of populations.

This will lead to a description of the objects, method and results of a survey carried out in 1966 among a random sample of adults in Edinburgh into the level of local information regarding the causes, course and prospects of cure of mental illness, and into some of the prevailing attitudes to the mentally ill and to ex-mental patients.

CHAPTER I

REVIEW OF THE LITERATURE

SOCIOLOGICAL AND HISTORICAL PERSPECTIVES

It is not feasible to contemplate the subject of community attitudes to mental illness or the mentally ill in complete isolation since this is a topic which encompasses such a wide range of interest, interaction and change. The treatment of the mentally ill at any one point in time or any geographical locus has always been in some sense a reflection of the cultural climate or beliefs of the society in which the sick are so identified, and the modes of treatment meted out to a society's deviant members have afforded an illustration of the conception of itself which a particular society holds and of the limits upon behaviour which it has seen fit to impose within its boundaries.[1]

Until recently the historical or anthropological or, in the widest sense, narrative approach has been the method of choice for describing this field. This viewpoint has the advantage of providing perspectives and of giving to apparent novelties in opinions or therapeutics the corrective of comparison with previous changes/

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1 Bockhoven has written on, "Some relationships between cultural attitudes towards individuality and care of the mentally ill" in, 'The Patient and The Mental Hospital', ed. Greenblatt, Levinson and Williams (1957).

changes of a similar kind. Recently the term transcultural psychiatry has been given to a speciality which spans the boundaries of psychiatry and social anthropology[2] and which endeavours to make allowance for the cultural setting in which apparently bizarre phenomena are manifested. Denko (1964) has reviewed the literature on what she terms, "exotic psychiatric syndromes", to illustrate her thesis that persons who develop mental illness do so in a way which is prescribed by their society.

As one example of a culturally conditioned syndrome, Lee (1961) has discussed an outbreak of "crying" among Zulu women whose traditional life pattern had suddenly been disrupted by the pressures of urbanization. Lee argued that the content of their symptoms could be explained in the context of their stressful cultural situation.

Rawnsley and Loudon (1965) made an epidemiological investigation into mental disorders in Tristan da Cunha. They were interested in two phenomena in particular, firstly, in a history of "spells" or hysterical attacks of some sort to which certain of the islanders had/

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2 See P.M. Yap (1951) "Mental Diseases Peculiar to Certain Cultures: A Survey of Comparative Psychiatry"; also "Culture and Mental Health", edited by M.K. Opler (1959) for a collection of essays, including "Some problems of Transcultural Psychiatry" by J. Fried and E.D. Wittkower. There is also Opler's short chapter, "Anthropological Aspects of Psychiatry (1959), in 'Progress in Psychotherapy', Vol. IV.

had succumbed in an epidemic about thirty years previously and, secondly, in the frequency of headaches in the population at the present time. They considered that some at least of the headaches constituted a neurotic symptom which was a socially acceptable indicator of anxiety and which spread through the community in a rather similar fashion to the previous hysteria. Referring to this study and others in another paper, Rawnsley (1965) observed: "Social attitudes may make a powerful contribution to determining the occurrence and content of psychopathology".

One of the best known and most thorough enquiries into the possible relationship between culture and mental disorders has been the epidemiological survey carried out by Eaton and Weil (1955) among the Hutterites. The authors were very cautious in their conclusions, but they tended to agree that the results did indicate the influence of social and cultural variables (such as religious beliefs) upon the typology of psychiatric symptoms, at least within a homogeneous and cohesive society. However, they were prepared to grant that theories of social-genetic drift might just as well explain their findings. As they pointed out, "Questions of the specific relationship of sociological variables and symptoms of mental disorders are largely unexplored. This area in psychiatry must be mapped before much progress can be expected in applying quantitative/

quantitative sociological findings to the planning of psychiatric prevention and treatment programs".

Whilst acknowledging the importance of social factors in determining the clinical picture of insanity in any culture, Lewis (1956-1957) also warned that hasty conclusions should not be accepted too easily. He pointed out, "The causation of particular psychiatric syndromes is extraordinarily difficult to establish, even in our own familiar culture, it is therefore all the more difficult to arrive at correct conclusions regarding societies of whose social structure and beliefs we can have at best only an imperfect knowledge".

The interpretations put upon clinical symptoms by a psychiatrist are as likely to reflect his own training and the school to which he owes allegiance as they are to indicate the significant relationship for the patient concerned between his signs and his social situation. This distance between the psychiatrist and his client will be the subject of later reference, meanwhile it is important to acknowledge the liberalising influence of some of the general concepts of transcultural psychiatry, whatever their limitations in the particular.

Historical accounts of the varying treatments meted out to the mentally ill from time to time at least purport to be relatively straightforward/

straightforward and factual. Even into this area of enquiry, however, differences may intrude depending on individual historians' analyses of motives.

Carstairs (1959), referring to the 'Social Limits of Eccentricity', has traced in outline some of the developments in psychiatric practice in Britain over two centuries, and the same topic[3] has been exhaustively dealt with by Jones (1955) in her book, 'Lunacy, Law and Conscience'. Both have drawn attention to the brief period during the mid-nineteenth century when, "moral treatment" prevailed and patients were regarded as human beings with individual rights like anyone else.

The position in Scotland a century ago has been picturesquely described by Mitchell (1864), one of the Deputy Commissioners for Lunacy, in a book entitled, 'The Insane in Private Dwellings'. One measure of the extent to which the mentally ill of those days were being supported by the community is an estimate which he quoted to the effect that forty-four per cent of the insane[4] in Scotland were then being cared for outside asylums.

Mitchell/

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3 Chapter IV of the Report of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency (1954-1957) provides another historical summary of the subject.

4 In Mitchell's time the term, "insane" included the mentally subnormal as well as the mentally ill.

Mitchell had some penetrating remarks to make, anticipating recent observations on the relationship of social class and mental illness: "The sure and broad pauperising effects of insanity are not generally well understood; the numbers of those who become paupers through insanity being vastly greater than those who become insane through poverty".

He also observed, "To a great degree the insane are harmless and manageable, or otherwise, according to their surroundings". Later, in the course of an account of his statutory inspection of lunatics at home, he described in vivid terms the case of a certain "melancholic widow" and remarked on the effects of her continual presence upon the rest of her family:

"How the presence of such a patient in a small house must act on the other members, I need scarcely point out ..... visitors are discouraged ..... the house and family eventually become isolated from friends and neighbours. It would be difficult to imagine healthy merriment in that family. Light-heartedness and energy both disappear from their joyless home. Poverty comes, and in its train indifference. Mental depression and underfeeding lead to disease and, if the hereditary predisposition to insanity be strong, this disease may be the development of lunacy in other members of the family ..... ".

One hundred years ago an enlightened official, whose primary concern/

concern was the proper care of his charges, had been facing up to the familial consequences of mental illness. He was already appreciating what has been recently termed, "The Burden on the Community" (Nuffield Provincial Hospitals Trust, 1962), and he evinced an awareness of the complex interaction between social circumstances and personality type which is sometimes claimed as the product of sophisticated modern theories.

Henderson (1964) has traced the more humane and enlightened treatment of the mentally ill in Scotland[5] to the association between the French doctors Pinel and Esquirol and contemporary Scottish physicians and alienists. The liberating policies of Pinel in the Paris mental hospitals was conveyed to those Edinburgh doctors who were prominent in the management of the Royal Edinburgh Hospital for Mental Disorders.

Although Henderson has called the boarding out system, "the first medico-social experiment in the community care of the mentally affected", he pointed out at the same time the mundane considerations of economy which had been prominent in its introduction. It saved bed space and was cheaper than hospitalization.

This

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5 For the Highlands of Scotland Martin Whittet has provided an account of some of the beliefs about mental illness which formerly prevailed there in an article on Celtic Medicine (1964).

This kind of community care, as is well known, had originated at Gheel, near Antwerp. Miraculous cures of the insane were reputed to occur at the place of a shrine in memory of the Irish Princess, Dymphna, who was murdered by her mad father. When the mentally afflicted began to flock there in hopeful hordes the local population began to provide them with accommodation, and, incidentally, to utilise their services in menial employment. The arrangement was mutually beneficial, the sick being provided with generous care by the local population who at no time regarded their presence as burdensome or dangerous. The boarding system, later regularised and put under control, is still maintained in Gheel.[6]

The continuing discussion around the provision of the most recent Mental Health Act (1959) illustrates the uncertainty which precedes and accompanies changes in legislation regarding the care of the mentally ill.

The Royal Commissioners who prepared the Report on the Law relating to Mental Illness and Mental Deficiency 1954 - 1957 drew upon their reassuring impressions that there had already been considerable/

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6 In very different surroundings, the village of Aro in Western Nigeria, the boarding out system is now being used for Yoruba mental patients by Lambo (1961).

considerable changes in public attitudes towards mental illness and the mentally ill. They stated:

"The general public now know more about mental illness and are more sympathetic to people suffering from it than ever before. An increasing number of people have friends or relatives who have been patients in mental hospitals, most of whom have spent a few weeks or perhaps months under treatment and have then come home to resume their normal lives, and first hand knowledge of the mental hospitals ..... is spreading ..... Members of the general public also learn about the work of the mental hospitals from time to time through the press, wireless or television. Popular interest in science and medicine certainly extends to psychology and psychiatry ..... Indeed we believe that most people today would at least pay lip service to the principle ..... that the mentally ill are sick people and that mental institutions should be thought of primarily as hospitals for the treatment of illness".

They went on, however, to mention the contrary impression that, "There is still a great deal of ignorance and prejudice towards anything 'mental' which will not be overcome if it is ignored or discounted. Sensational and unthinking articles sometimes appear in the press .....".

An interesting light on attitudes in the Soviet Union is cast by/

by Rokhlin (1959): "Patients or their relatives sometimes apply to the physician too late, when the disease has already taken deep root. This is sometimes due to the fact that the patient hides his morbid experiences and does not tell anybody about his delusions. In other cases the people around the patient at first misinterpret his abnormal behaviour as a malicious manifestation of his bad character. Lastly, the prejudices still persisting in some people in connection with mental diseases forces them to delay taking medical advice because of false shame or of the erroneous belief that all mental diseases are presumably incurable anyway. One of the tasks of the dispensary is to eradicate the prejudices, to spread the right ideas about mental illness and to explain the necessity for their timely treatment which usually yields the best results".

In Britain, the inauguration of fresh legislation, with the emphasis upon voluntary admission and treatment, should be regarded not simply as a reflection of "more enlightened" community attitudes but, simultaneously, as a stimulus to further change. The law does not merely follow changes in opinion but is itself a significant factor in their formation.

It remains a matter of some importance to discover or try to discover the actual state of present public opinion on these subjects, since/

since the views which are held on the adequacy or effectiveness of available treatment facilities will be a factor in deciding the number and types of people who take advantage of them. And any attempt to shift the burden of patient care onto the community will have to take into account the community's readiness and fitness for the therapeutic task. There are, in other words, clear implications both for epidemiology and for policy. As Sir Aubrey Lewis has said (1956-1957), "The attitude a society has towards mental disturbance and its treatment is itself an important, far from static force, determining how far existing facilities are availed of and how far different or more extensive facilities are demanded".

But in the words of Carstairs (1959), "There is no clear cut criterion of what constitutes a psychiatric case. Whether a person is regarded as in need of medical treatment is always a function of his disturbance of behaviour and of the attitudes of his fellows in society".

The same point has been made in the World Health Organization Report on Social Psychiatry and Community Attitudes (1959), where it is stated, "In whatever way a society may be organised, it is not so much the type of mental disorder that varies as the community's reactions to abnormal behaviour". The report goes a stage further and insists, "The first priority in attempting to create favourable attitudes is to determine what are the present attitudes in the communities under consideration".

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One reason why there have not so far been many systematic studies of community attitudes to mental illness has been the difficulty of defining the subject matter.

The quotation from Carstairs has neatly stated the dilemma, "There is no clear cut definition of what constitutes a psychiatric case". As will appear later, this deficiency has bedevilled the attempts to estimate the incidence of psychiatric illness in general practice, meanwhile its relevance lies in the relationship of mental illness to other forms of behaviour which are deemed deviant by society. It has been suggested that some of the attitudes which are operative in the case of the mentally ill may also be those which relate to other sorts of unconventional behaviour.

From the sociological point of view mental illness can be regarded as simply a special case of deviant behaviour.[7] The sociology of deviance has already assumed an extensive literature of its own and it would be impracticable and unreasonable to review it within the present context. Nevertheless there are sociologists who have gone the length of casting doubt upon the usefulness of the concept of mental illness as a branch of medicine. Erikson/

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7 Thus, mental illness is contained within the concept of deviance, so that all mental illness is deviant behaviour although all deviant behaviour is not mental illness.

Erikson (1957) for example, discussing "Patient role and social uncertainty", is only one of many who have drawn attention to the difficulties attending a person's assumption of the particular role of mental illness. Erikson maintained that "the public's scepticism about psychiatry as a medical tradition ..... is not simply a consequence of ignorance or emotional resistance; it has a fairly wide basis in fact and is presented in a framework of fairly sound logic". He went on to supply examples of the contrast between medical and psychiatric, "treatments" and to recommend the European idea, then gaining support, of the therapeutic community, with concentration upon re-education and resocialisation rather than therapy.

The question of differences in American and British services for the treatment of mental illness and possible national differences in prevailing attitudes towards the mentally ill are to receive attention later. Meanwhile a subsequent paper by Erikson (1962), in which he considered the possible functions of deviance[8] for society at large, is relevant.

It is commonplace to regard deviant behaviour, whether in the form of crime, illness or social unorthodoxy, as something almost by/

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8 Merton has previously dealt at length with the subject of deviant behaviour in Chapter IV on, "Social Structure and Anomie" in 'Social Theory and Social Structure' (1957).

by definition undesirable and consequently in need of elimination or treatment. But if this is the case, then all societies to date do appear to have been singularly ineffective in these respects, since crime continues and mental aberrations of one sort or another are, like the poor, always with us.

Faced with this paradox Erikson (1962) has ingeniously suggested that societies require a segment of behaviour which they designate deviant in order to establish for themselves the boundaries of normality. The following are some of the points which he makes:

"A social norm is rarely expressed as a firm rule or official code. It is an abstract synthesis of the many separate times a community has stated its sentiments on a given issue ..... Like an article of common law, the norm retains its validity only if is regularly used as a basis for judgement. Each time the community censures some act of deviance, it sharpens the authority of the violated norm and re-establishes the boundaries of the group".

"Human groups need ..... to describe and anticipate those areas of being which lie beyond the immediate borders of the group ------ the unseen dangers which in any culture and any age seem to threaten the security of group life".

"..... Deviance cannot be discussed as behaviour which disrupts/

disrupts stability in society, but is itself, in controlled quantities, an important condition for preserving stability".

Erikson provides a further sociological insight into the definition of deviant behaviour by drawing attention to the ritual nature of the procedure which accompany a person's transferral to the deviant role. Whilst his main illustration is from the criminal trial and its accompaniments, he draws another analogy from the confrontation of a deviant suspect and a psychiatrist, followed by diagnosis and formal placement in the role of patient, in which role he is expected to remain for an indeterminate time.

Further, the elaborate ceremonies which attend the commitment of a patient to a psychiatric hospital are unmatched by any corresponding public formalities upon discharge. The latter tends, at least in our society, to be quite casual and inconclusive, leaving the person with his assigned role of "mental patient" still clinging closely about him. As Erikson says, "From a ritual point of view, nothing has happened to cancel out the stigmas imposed upon him by earlier commitment ceremonies: the original verdict or diagnosis is still formally in effect. Partly for this reason, the community is apt to place the returning deviant on some form of probation within the group, suspicious that he will return to deviant activity upon a moment's provocation".

Erikson wonders whether we have anything to learn from "those cultures/

cultures which permit re-entry into normal social life to persons who have spent a period of 'service' on society's boundaries".

In this connection it may be of interest to note that in West African Yoruba culture (Prince, 1962) it is not only a patient's commital to the psychiatric care of local specialists which is accompanied by ceremonial. The end of a period of psychotherapeutic and drug treatment in the traditional setting is marked by an elaborate ritual. The patient stands in a river whilst a dove is sacrificed on his head. He is then washed with the bird's blood before its carcase is cast downstream. The garment which he wore as a patient is next removed from him and similarly relegated to the waters, while an incantation is pronounced which can be translated thus,

"As the waters of the river will never flow backwards, so may the sickness never again return to this man".

There follows a general feast, with drumming and feasting, paid for and prepared by the patients' relatives who have travelled specially to the healer's compound to receive back their restored member. Thus the assurance which everyone feels in the cure is symbolised and made explicit in a public ceremony which marks at the same time an end and a new beginning.[9]

Scheff (1963) is another sociologist who has elaborated a model of/

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9 Like an American college graduate's "commencement".

of mental disorder based upon the deviant behaviour of an individual and those reacting to his behaviour. He points out the effect which prevailing cultural stereotypes can have in determining the pattern of symptoms produced by those who, once they are labelled deviant, proceed thereupon to act in accordance with expectations.[10] Moreover, in some cases, the labelling persists and the ex-mental patient may encounter positive discouragement on the part of others when he tries to return to normal activity and employment.

Kituse (1962), in considering some of the problems of theory and method in the study of societal reactions to deviant behaviour, has made the rather obvious point that any particular form of behaviour per se cannot be classed as deviant, the definition always rests upon the viewpoint of the observer. He went on to insist that, "A sociological theory of deviance must focus specifically upon the interactions which not only define behaviour as deviant but also organise and activate the application of sanctions by individuals, groups or agencies. For, in modern society, the socially significant differentiation of deviants from the non-deviant population is increasingly contingent upon circumstances of situation, place, social and personal biography, and the bureaucratically organised activities of agencies of control".

Kituse/

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10 There are familiar analogies with this in the field of physical medicine, as for example, the numerous examples of people whose activities have been strictly limited as a result of the spurious diagnosis of "weak heart" made when they were children.

Kituse was concerned with deviant behaviour of all kinds and did not, like Erikson and Scheff, concentrate upon the special case of what psychiatrists term mental illness. But it is striking how easily, in the above quotation, the term "mental illness" could in fact be substituted for "deviance", providing thereby a summary of the mental patient's position.

The point has been developed at length by Goffman who has followed what he calls, 'The Moral career of the Mental Patient' (1959, 1961) and whose interest in this special group in the community is brought out again in his book on 'Behaviour in Public Places' (1963).[11] Goffman picks out many, "situational improprieties" which the ordinary person in society strives hard to avoid but which are a common feature of the kind of behaviour which is deemed to be mentally disturbed. A person's lack of concern for the accepted rules of social conduct can be sufficient to label him at the least odd and at the most mad. The actual judgement made by society in any particular case will be dependant upon the form which his lack of concern takes and also upon the rules involved.

At the same time, within an institution for the mentally ill, certain forms of behaviour can be observed to develop, with their own sets of rules and expectations. The participants in any such small society or "Total Institution" (Goffman) act toward one another in/

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11 See also Goffman's analysis of the situation of the ex-mental patient, and of society's other outcasts in 'Stigma' (1963).

in ways which anticipate particular responses. They are seldom disappointed. Thus much of the more violent and bizarre forms of behaviour which were once a common sight in asylums are no longer to be seen.[12] Where custodial care and physical control were once considered absolutely necessary the emphasis now is all upon individual freedom and lack of restraint.

The effects which the definition of a situation by those involved will have upon its development in practice was first stressed by the sociologist W.I. Thomas (1919). This very useful concept of the definition of the situation is, of course, relevant not only within institutions but in the outside world and has a close bearing on the successful rehabilitation of former mental patients since the expectations of family, friends and potential employers may be critical to the patient once he is discharged.

Wilkins (1964) carries the idea of deviant, "sub-cultures" a stage further and sees what the larger society calls criminal behaviour as falling within the normal curve of values for the criminal society. The relevance for Britain of this concept of criminal sub-cultures among deprived groups in society has already been called in doubt (Rose, 1966) and it is not a particularly fruitful/

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12 Manis et al. (1965) raise the interesting point as to whether the present day infrequency of manic behaviour among mental patients in the United States may indicate the cultural acceptability of mild manic disorders in American society. Further reference will be made to their work in a later chapter.

fruitful one for understanding the behaviour and public standing of mental patients within the wider community. It is only whilst they are artifically incarcerated within an institution that the mentally ill can be regarded by others as a completely separate and, in some sense, almost sub-human society. Much of the debate which has gone on in America over public attitudes to the mentally ill has probably involved an image of the mentally ill patient, of low social class, confined in a public asylum.

But the reception of an ex-mental patient by the community or his previous assignment to such a position cannot, with respect to the sociologists, be adequately understood solely in terms of deviance.

As the phrase itself proclaims, mental illness has at least to some extent already come to be regarded as falling within the bounds of medical competence, with the ensuing benefits in terms of care in place of custody and treatment in exchange for chains.

Yet there are undoubted difficulties in the equation of mental and physical illness. It would be too easy to assume that mental illness can be seen simply as a medical misfortune and to expect that the reactions to its insidious beginnings would turn out to be a function of the assumption of, "The Sick Role".

Talcott Parsons (1951; 1964) is responsible for the now famous list of conditions which he believes accompany the attribution of this/

this role in American society. He has specified, "Illness ..... is most generally characterized by some imputed generalised disturbance of the capacity of the individual for normally expected task - or role - performance". He goes on to state that this "disturbance" has four distinguishing features: firstly, the incapacity that the person suffers is beyond his own power to overcome, that is to say, by an effort of will; secondly, the sick person is forthwith exempted from his normal role and task obligations; thirdly, although this is a "legitimated state", it must be recognised by the sick person as inherently undesirable; fourthly, the sick person, and his family have an obligation to seek competent help. The sick person, says Parsons, when permitted temporarily to adopt the sick role, makes some secondary gains in the process, he can relax and let others take over his responsibilities. Therefore, great stress has to be laid upon the feeling that illness is undesirable. And the sick have to be isolated, otherwise the idea might catch on and everyone would fall ill .

Parsons makes a fine distinction between tasks and roles[13] and defines physical illness as an incapacity for task performance, whereas mental illness is more serious in that it involves an incapacity for role performance.

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13 "Role ..... is the organised system of participation of an individual in a social system with special reference to the organisation of that social system as a collectivity". "Task ..... is that subsystem of a role which is defined by a definite set of physical operations which perform some function or functions in relation to a role and/or the personality of the individual performing it".

Even when due allowance has been made for the relative obscurity of Parson's sociological language, it does not seem as though this definition of mental illness can be the ultimate one. There are, for example, cases of neurosis persisting throughout many years where a person still manages, after a fashion, to perform most of their social roles. Parson's definition requires in each case the fulfillment of all four features of disturbed role performance and he might well say that the neurotic who had not, "broken down" was not mentally ill.[14]

Moreover, incapacity for role performance is something which requires a judge. The person most concerned is often either reluctant or unable to recognise his own impairment of capacity, whilst his close relatives tend either to charge him with responsibility for his incapacity or else to obscure the implications of his faulty functioning for a considerable period of time. If, however, the psychiatrist is to be the judge of impaired capacity for role performance the potential patient or his relatives have still to take the initial step of seeking him, and it is this first move, this appropriate reaction in the face of unusual behaviour, which is so often in doubt.

This is not to dispute the importance of the sociological parameters/

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14 The separation of neurotics into those who have and those who have not "broken down" is a crucial one for both psychiatric epidemiology and treatment; Are the psychiatric services concerned solely with "the tip of the iceberg" dimensions of diagnosed mental illness? What determines individual "breakdown", and so on.

parameters of mental illness but merely to deny them a monopoly of insight into all its manifestations and effects.

Whilst it is possible that Talcott Parson's four stages or expectations may underlie the contemporary American middle class method of coping with physical illness, it is exceptional for the course of mental illness in a family to fall so neatly into categories of expected behaviour on the part of all concerned, and there would seem to be reason to blame the differences between physical and mental illness for at least some of the difficulties which people experience in recognising and dealing with the latter.

Even in the case of complaints which might superficially be judged physical it has been shown (Zola, 1963) that the patient's ethnic background is one of the factors which will decide whether a doctor recognises the presence of underlying psychiatric problems. Another important study on the differing cultural responses to illness has been done by Zborowski (1952), who noted clear differences in attitudes to pain and behaviour under pain as between Jews, Irish, Italians and Americans of Nordic stock.

The whole subject of illness behaviour has recently expanded as its complexity has received recognition. Some of those who have studied it are well known, for example, applied anthropologists like Benjamin Paul (1955) and Lyle Saunders (1954). The American literature is full of accounts of sickness behaviour and definitions of/

of health and disease ranging from New Mexico and South America to the Far East.[15]

Much of this work does not presume to be more than descriptive. But Mechanic has conducted more systematic and experimental researches into the relationship between perceived stress, illness and the inclination of individuals to adopt the sick role - as measured by inclination to use medical facilities (Mechanic and Volkart, 1960; Mechanic and Volkart, 1961; and Mechanic 1962 and 1966).

These studies were carried out on male college students. Mechanic and his colleagues found that among those who were already inclined to use medical facilities, stress played an important part in the initiation of the medical visit.

Mechanic points the particular relevance of the study of illness behaviour to psychiatric practice. It is always difficult for a psychiatrist to separate a patient's complaint from the social circumstances in which it has arisen. "What may differentiate some psychiatric patients from many others not regarded as ill by themselves, " Mechanic observes, "are different patterns of illness behaviour".

Mechanic/

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15 Apple (1960), editor of, "Sociological Studies of Health and Sickness" has collected a series of essays in this field, some of them by writers who will be quoted in later chapters.

Mechanic goes on to describe a possible dilemma of the psychiatrist who is acting in good faith, "The typical psychiatric practitioner"[16], he states, "will usually assume that the patient's complaint arises from some underlying psychological or developmental problem ..... But the study of illness behaviour implies another possible interpretation of the complaint; it may be the result of an exagerrated illness behaviour pattern. And there are certainly some cases where the psychiatrist might better spend his time teaching the patient to focus less rather than more on his psychological state".

Mechanic's warning against an excess of psychoanalysis is certainly welcome. But by introducing the adjective "exagerrated" he immediately begs the question, because he implies that there exists some kind of norm or ideal of illness behaviour. This is in contradiction to his own expressed views elsewhere, when he has said, "The study of illness behaviour attempts to create a better understanding of various patterns of seeking care without making ethical judgements of the behaviour itself".[17]

Some of the sociological perspectives of psychiatric illness have been very competently discussed in an admirably undoctrinaire fashion by Pat Patten (1961; 1963). She has drawn attention to the confusion which results because of the different concepts/

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16 Mechanic is describing the American situation.

17 My italics.

concepts of mental illness held by "experts" and the lay public. Her observations were prompted by interviews which she carried out with the relatives of mental patients.

She has very clearly perceived and enunciated the problem which arises from the fact that, to use her own words, "The definition of mental illness held by those who are implementing the medical services[18] is not the definition of either 'illness' or 'mental' held by the sections of our community for whom the services are intended, and the behaviour that we are calling 'illness' and wanting to treat by medical means, they are calling 'behaviour' and wanting to treat by moral means ..... What appears to be causing the trouble in our community (i.e. as compared to some other cultures) is that, although the people operating the services may use the same terms as the people using the services, the meanings of words, the expectations, associations and implications which are subsumed under a concept, differ from one group to another".

Patten has pointed out the contrast, which was mentioned above, between the clear lines of action people know they must pursue when someone/

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18 Unfortunately this definition is by no means an agreed matter, even amongst "experts". Hill (1962) sees the question of definitions in psychiatry as "the most urgent problem which the psychiatric epidemiologist must tackle. Without doing so there will be no possibility of carrying out meaningful work in this field, no possibility of comparing results as between one part of an enquiry and another, as between two enquiries carried out at different places or at different times". From, 'The Burden on the Community', Nuffield Provincial Hospitals Trust.

someone becomes physically ill and the confusion which arises among relatives at the onset of a mental illness. Efforts are made to exhort the patient or else to explain away individual episodes of odd behaviour "reasonably" by reference, for example, to some preceding "upsetting" incident or experience. People feel that the very inconsistency of behaviour on the part of the person concerned, the fact that he sometimes behaves or talks perfectly normally, "proves" that he cannot really be "insane", in the popular sense of the word. Insanity, Patten thinks, conjures up for most people a condition of extreme irrationality.

The multiplicity of models in the light of which mental illness can be viewed has been the subject of a recent paper by Siegler and Osmond (1966). These authors divide the ways in which mental illness may be seen according to six possible modes, each with its own implications regarding causation and management. Their categories are not entirely satisfactory, although they have usefully re-iterated the differences between the various schools of thought amongst psychiatrists.

For the purposes of the present discussion, however, the models of mental illness can perhaps be reduced to three, sociological, psychiatric and popular.

At first it might seem scarcely surprising that ordinary people should encounter difficulty in sorting out their experiences when sociologists and psychiatrists are themselves still so confused. But/

But this would be to adopt a superficial approach to the subject. Both sociologists and psychiatrists have for their subject matter, or clinical material as the case may be, the behaviour of ordinary people in society. It is their methods of sorting and categorising which differ and the points at which they choose to place their emphasis. These different approaches are in turn determined by their separate purposes, the sociologist's being the understanding of man in society, whilst the psychiatrist is mainly concerned with understanding and assisting the individual.

Both the sociological model and the medical model are necessary to a total understanding of mental illness. The viewpoints must not be regarded as mutually exclusive but as complementary. Thus the improvements in the treatment of the mentally ill which have taken place in this country during the past fifty years have not merely benefitted the patients concerned but have undoubtedly altered the attitudes of society towards both the patients and the treatments. For example, advances in drug therapy have made out-patient care much more widespread, thereby bringing people into close contact with others who have been or still are under treatment. Similarly, improved physical surroundings within the mental hospital, in the form of cheerful and comfortable decor, not only makes patients happier, but induces relatives and visitors to revise their former ideas of the institution's grim image.

Meanwhile/

Meanwhile, as Erikson has said, sociological insights can contribute to the better management of patients who are necessarily confined to institutions for a time and can point to the similarities, rather than the differences, between life inside and outside.

As well as the sociological and the medical model, however, there remains the model of mental illness held by the lay public. Not having the benefit of specialisation in either discipline, ordinary people have perforce acquired their ideas on this topic in a highly haphazard and casual fashion, as part of their general learning process. What evidence is available - and this will be the subject of the ensuing chapters - tends to indicate that the public still lag behind the views of the various experts and are continuing to retain diverse remnants of stereotypes from an earlier era of treatment and theory. It is in no way strange that this should be the case. But at the same time the learning process is still continuing; there is no necessary, final division between the "expert" viewpoint and the public understanding, it is simply a matter of degree.

In the chapters which are to follow it is as well to bear in mind that all the learned papers have been composed by "experts", from their own point of view, with their own special models and categories in mind. When psychiatrists, for example, refer to "Enlightenment" they are in fact applauding the degree of concordance between the views of their subjects and the views which/

which they themselves hold. When they approve "high tolerance levels" they are making the assumption that maintainance of the mentally ill within society is desirable, just as, when they deplore "failure to recognise mental illness" they are making the rather different assumption that behavioural oddities and "problems" should early be brought to their professional attention. Particularly in the American literature, the emphasis is not merely medical, nor even psychiatric, but more explicitly psychoanalytic.

In other words, the contrast which exists is between the current concepts of experts and the continuing concepts of their clients. But there is no need to become resigned in consequence to a kind of sociological determinism or to demand that the medical model should forthwith be abandoned. Stereotypes can and do change; although they will never catch up with the latest theory they are presently in process of overtaking the outmoded theories of the past.

There is one further difficulty inherent in the particular conception which sees mental illness not simply as illness but as part of a continuum of behaviour. Liberalising tendencies have led to the prevailing "expert" view that mental illness should no longer be the occasion for sermons, exhortations and restraints. But the same humane influences which have lessened the idea of personal responsibility for personality traits have paradoxically blurred the boundaries between illness and health at the very time that the medical model is being acclaimed. It would, therefore, be naive to/

to imagine that there exist, in some sense, a set of "true" diagnostic categories and that well-intentioned mental health educators have simply to make ordinary people aware of these categories so that, at the first signs of disease, they may hasten to procure proper treatment. Such a Platonic viewpoint is doomed to almost certain disappointment.

Perhaps the most that can be hoped for is an increasing concensus among practising psychiatrists in any one country regarding their own definitions, whilst remembering that one of the pitfalls of precision still lies in the distance which can yawn between psychiatrist and public.

CHAPTER II

REVIEW OF THE LITERATURE (CONTD.)

STUDIES OF THE ATTITUDES AND OPINIONS OF SPECIAL GROUPS IN THE COMMUNITY

The last chapter, having been concerned in the main with the broad theoretical background against which mental illness can be viewed, ended by drawing attention to the central problem of definitions in this field, as a matter of the first importance for communication not only between specialists but also between the psychiatrist and his client.

This chapter will describe a number of investigations into the state of opinion and the attitudes of groups of people for whom mental illness has a particular relevance on account of their professional or personal interests.

This type of investigation, whose aims and methods are clearly defined and whose modest results are statistically analysed, is primarily an exercise in epidemiology. The ecology of opinions and attitudes is as much in need of mapping as the geographical pathology of disease and it is to be hoped that the accumulation of careful studies/

studies of this kind can be an aid to practising psychiatrists and social theorists alike.

The literature regarding the attitudes and opinions of certain special groups is very extensive and the present account does not presume to be comprehensive.

It is not surprising to discover that a large number of studies have selected for their subjects psychiatrists, doctors, medical students and nurses of all grades. These people are at once easily accessible and readily persuaded of the importance of research projects in a corner of their own field of operations. A smaller number of investigations have extended to the potential employers of ex-mental patients and to those professional people in the community, teachers, lawyers and the like, who might be expected to give a lead to public opinion in these matters.

A number of what seem to be the more important surveys among these various groups of subjects will be discussed before going on in the next chapter to consider what has been published regarding the viewpoint of that very interested and interesting group, the patient's relatives.

Since the present study is primarily concerned with community attitudes to mental illness, the community in question being the broad one of the outside world, there is no particular relevance in investigations made into the views of nurses, attendants, ward orderlies/

orderlies and so on, whose activities are confined to the inside of a mental institution.

Recent interest in the concept of the, "Therapeutic Community" has inspired researchers to calculate a multitude of correlations between the personalities of staff members and their professed views.[1]

The Psychiatrists' Viewpoint

The point of view of psychiatrists on the other hand is undoubtedly important since they have a "gate keeping" function for the hospital and also perform a therapeutic role in clinics outside. How they perceive a possible patient and his problems is therefore of considerable moment for the person concerned. Their behaviour in the initial interview situation may indeed determine whether that particular patient ever returns.

Kreitman/

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1 Examples of such investigations are to be found in articles by Cohen and Struening (1962), employing their specially constructed "Opinions about Mental Illness" scale; Vernallis and St. Pierre (1964), using the same scale, on volunteer workers; Hicks and Spaner (1962), using a scale compounded out of several others, on nurses in training; Souelem (1955), with her own scale, on patients; Klopfer, Wylie and Hillson (1956) using Souelem's scale on various staff members; Gilbert and Levinson (1957) using their own Custodial Mental Illness scale on hospital aides; Gynther and Brilliant (1964) using the C.M.I. scale on patients; Gelfand and Ullmann (1961) using Cohen and Struening's O.M.I. scale on nursing students; Carstairs and Heron (1957) using a modification of Gilbert and Levinson's C.M.I. scale on hospital personnel.
See also "The patient and the Mental Hospital", ed. Greenblatt et al., 1957 in which the Carstairs and Heron study is reported among others.

Kreitman (1962) carried out a study of attitudes among psychiatrists at the Maudsley and Royal Bethlem Hospital in London. He was concerned with what he regarded as two important aspects of psychiatric orientation. He considered that psychiatrists would fall roughly into two groups: firstly, those who had an organic orientation, being primarily interested in the organic aspects of disease, deriving their conceptual models from general medicine and concentrating on physical methods of treatment: secondly, a group with a primary analytic orientation who would be more anxious to "understand" the patient, probe his unconscious mind and treat him by psychotherapy. Having constructed two scales, "O" and "A", to measure these attitudes and subjected them to trial by a small panel of judges, he then used them on 78 psychiatrists, who at the same time completed a number of personality scales. Kreitman's main finding was that increasing psychiatric experience was associated with an increase in score on the "A", or analytic scale, and a fall in score on the "O", organic scale. However, duration of general medical training turned out to have a converse orientation. In other words, doctors who had come to psychiatry after a relatively prolonged period as general physicians seemed to be persisting in their original interests and to be relatively resistant or unsympathetic to the psychoanalytic point of view.

The study by Manis et al. (1965) was mentioned in the last chapter/

chapter in connection with the changing pattern of symptoms in mental illness. Their primary aim was to compare the conceptions of mental illness held by a group of psychiatrists with those of a sample of the general public in Kalamazoo County, Michigan. They had anticipated that the public would be more inclined to stress troublesome behaviour as indicative of mental illness, whereas psychiatrists would perhaps perceive, with more subtlety, the ominous possibilities in what the authors called, "less disruptive behaviour".

Accordingly they prepared and had judged a list of twenty very short statements describing types of behaviour characteristically aggressive, bizarre, grandiose, manic and emotional, as well as the opposites of all these modes of acting.

The responses of a group of psychiatrists were compared with those of a random sample of the population. The authors were surprised to find that both the public and the psychiatrists held fairly similar views but that neither group placed special stress on disruptive behaviour. "Persecutive, bizarre and emotional behaviour", they found, "were more apt to be considered indicative of mental illness than manic, conformist, grandiose or depressive behaviour".

They were inclined to conclude that manic, conformist, depressive and grandiose behaviour are nowadays becoming less fashionable indicators of mental illness and (as noted on p. 21 above), they/

they speculated upon the increasing acceptability of mild mania in successful Americans.

Although the group of psychiatrists tested by Manis et al. was too small to show many different orientations, the authors quote the words of Pasamanick and his colleagues (1959) in reference to the lack of consensus among psychiatrists in their diagnoses, " ..... equally competent clinicians as often as not are unable to agree on the specific diagnosis of psychiatric impairment ..... Any number of studies have indicated that psychiatric diagnosis is at present so unreliable as to merit very serious question when classifying, treating and studying patient behaviour and outcome". It seems, therefore, as though the outlook of the psychiatrist may well be of crucial importance in deciding the reception which a patient may anticipate on arriving for a consultation.

Social Class and Mental Illness

Hollingshead and Redlich's study entitled, "Social Class and Mental Illness" (1958) has become something of a classic in the field of American social psychiatry.[2] At this stage it is valuable to recall their observations on the impact which the class differences between psychiatrist and client can have upon the nature and outcome of the professional encounter.

On page 345 they state in the most uncompromising terms the nature/

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2 The second section of this study in Newhaven, Connecticut is reported by Myers and Roberts (1959) in the book, "Family and Class Dynamics in Mental Illness".

nature of the feelings which psychiatrists have toward their Social Class V patients:

"None of the therapists thought that friendships between these patients and themselves could be possible. They voiced hostile feelings towards the patients' values --- especially when the therapist was upward mobile from a Class III or IV background. These differences were more marked toward male than female patients. The therapists at least understood Class III values; this cannot be said regarding the values of Classes IV and V. The lack of understanding between therapists and patients is a major reason why neurotic patients in the two classes drop out of treatment much faster .....

..... Modern psychotherapy is most likely to succeed when communication is relatively easy between the therapist and the patient ..... When the therapist and the patient belong to different classes the values of the therapist are too far from those of the patient".

This fairly resounding condemnation of middle class norms is followed by the authors' observation that "insight therapy" is less likely to be grasped by the lower classes, who prefer therapy employing "magical methods". They hasten to add, however, that the lower/

lower classes do not thereby merit "supportive[3], suggestive or coercive techniques".

Hollingshead and Redlich are perfectly clear about the connection between cash values and the availability to analysis. Only the upper classes can afford to spend time and money in achieving "self-realization". The luxury of self knowing is denied to people whose "reality situations", as the authors so pertinently remark, "are tough, threatening and, in many respects, hopeless". Hollingshead and Redlich eventually concede, rather reluctantly it seems, that techniques which merely provide "insight" will possibly never completely solve such peoples' problems.

Gardner and Babigian (1966) in a recent comparison of the usage of psychiatric services in two parts of Monroe County, New York, have shown much higher rates for illness in the lower socio-economic groups. At the same time, the latter were the groups which had inadequate facilities for treatment. The difference in the treatment was most marked in those who were not diagnosed as psychotic. If they were from the higher income groups, an initial out-patient attendance was simply the prelude to a course of therapy, whereas/

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3 In this connection it is tempting to speculate on what may be the comparative success rates of treatment for psychiatric disorders in America, where to question "insight" therapy amounts to blasphemy, and in countries which just as determinedly eschew psychoanalysis. For example Rokhlin (1959) who has been quoted previously (p. 12), declares, "In the Soviet Union the psycho-analytic method of treating mental patients has fallen into disrepute", whereupon he proceeds to demolish his own conception of "Freudism".

whereas the lower socio-economic groups were in the main only making diagnostic contact with a hospital and, if they were not schizophrenic, they lost touch with the medical services thereafter.

The writers found that the discrepancy in the pattern of care was constant even when clinic (i.e. free) services were considered alone. They do not commit themselves to any explanation of their findings, saying merely,

"One can argue whether the different kind of psychiatric care for the two groups is a function of the patient's resistance, his suitability for out-patient treatment or bias on the past of the psychiatrist".

The Influence of the Mass Media

Nunnally (1957; 1958; 1961), of the Institute of Communications Research in Illinois University has made a very systematic study of the opinions of the public on mental health matters. His main research project will be described later, but he also compared the views of experts in the field (a sample of psychiatrists and psychologists, in this case) with those of the public and with the presentations of the subject on the mass media.

Analysing a sample of newspapers and of television and radio programmes was a very laborious task. Three hundred and twenty-three issues of newspapers among fifty papers of three circulation sizes published during one month were scrutinised. One issue of ninety-one/

ninety-one magazines was studied. All the programmes on one television station over one week were watched, and all radio programmes in one week from four different radio networks were monitored.

The general public consisted of a cross-sectional sample of the population in Knoxville, Tenessee, a sample from Champaign - Urbana and one from Eugene, Oregon.

The experts, contrary to the suggestions which have already been mentioned, tended to agree, in terms of the kinds of opinion statements presented in the questionnaire.

Nunnally found that reference to the topics of mental illness and psychology were appearing in radio and television more in the guise of fictional dramas than in programmes of a specifically educational or propaganda type.

Results showed that older people were more inclined to hold viewpoints which the majority of experts would reject - probably, Nunnally thought, because of the differing content of school studies when these people had their formal education. But outside the older age group (over fifty) and those with no high school education the population responses were not markedly different from those of most psychiatrists and psychologists. On the whole the public disagreed with the majority of the experts on those same issues in which the latter were disagreeing most among themselves, that is, regarding particular techniques for restoring personal maladjustments.

The/

The public seemed free of the worst misconceptions which the mass media were portraying. Nunnally found that, far from mediating between the experts and the public, the mass media were presenting bizarre and exaggerated pictures of mental illness, and falsifying its causes, course and cure prospects. The lay public were closer to the point of view of the experts than either group were to the concepts portrayed in the media.

Gerbner (1961), from the same Illinois Institute, made an extensive study of the mass media over sixty years (1900 - 1959) in order to trace the ebb and flow of attention given to mental illness topics and the mental health professions.

The average number of articles in popular magazines which related to mental health topics had not been rising steadily over the period. Although the space devoted to these subjects was undoubtedly much greater now that before World War I, there had been a number of marked fluctuations since then.

Gerbner was inclined to relate successive drops in the output of "psychological" subject matter with co-incidental economic recessions. Although his study raises a number of interesting speculations on the relationships of war, want and psychology, it is primarily a vast work of content analysis.

There have been other surveys into the effects of mass media on ideas on mental illness, notably by Belson (1957; 1963) whose work will be described later. Experimental psychologists have also been frequently/

frequently concerned with the effects of films in learning situations. For example, McGinnes, Lana and Smith (1957) reported on the effects of sound films on opinions about mental illness in community discussion groups. They believed that they had found that films shown in a coherent series could significantly modify opinions and beliefs, and that a series of mental health films, with or without audience participation through organised discussion, were effective in changing opinions and beliefs about mental illness.

Opinion Leaders and the Professions

The most important attempt to assess the orientations of community leaders has been the work of Dohrenwend and his colleagues from Columbia University (1962a; 1962b; 1963). They were aware that mental illness was a dubious conception, varying in meaning from one person to another, and also that individuals with troubles often approached certain professional people, such as lawyers, clergy and the police before going to a psychiatrist.[4] So these lay persons would be in a position to appraise deviant behaviour and direct individuals to one or another source of treatment. Their opinions were therefore clearly of importance. Nor did such people play a merely static role, but were in a position to change social norms within/

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4 It should be remembered that this refers to the American situation where fewer people have a family doctor, where treatment costs money, and where the patient can make direct contact with a specialist.

within their own spheres of influence.

Dohrenwend's study was in a Health District of New York City, an area which was predominantly lower middle and working class and whose inhabitants were Jews, Irish, Negroes and Puerto Ricans.

Questionnaires were administered to eighty-seven men who were recognised leaders of opinion in their district. The investigators wanted to find out the orientations of these community leaders towards types of abnormal behaviour which would be regarded as mental disorder by clinical standards and whether their orientations varied with the kinds of activity in which they were personally rated as playing a leading role. They were drawn from politico-legal, economic, educational, religious and "social-recreational" groups and were asked to indicate their responses to six brief case descriptions.[5]

Disregarding for the moment the comparison between the views of the leadership group and those of the community (as indicated by Shirley Star's work), Dohrenwend found that educational leaders had a high tendency to see the behaviour described in all six cases as indicating mental illness. The economic leaders were relatively low in recognition along these lines. The political-legal respondents surprised the investigators by being more like the educational/

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5 Drawn up by Shirley Star (see section on Community Surveys in Chapter IV) to illustrate paranoid schizophrenia, simple schizophrenia, anxiety neurosis, alcoholism, compulsive-phobic behaviour and juvenile character disorder.

educational than the economic leaders. They did recognise the disorders as in need of mental treatment, but they were disinclined to regard the conditions as serious.

By contrast, the religious leaders did perceive the disorders as serious, but were disinclined to recommend mental treatment for modes of acting which they personally did not regard as being primarily symptomatic of mental illness. Dohrenwend pictured the religious leaders as a profession which was acting virtually in opposition to psychiatry, whereas educational leaders were allied to it and economic leaders, in an intermediate position, were somewhat oblivious to its claims.

Whilst educational and religious leaders professed to have had a high experience of mental hospital patients, the economic and politico-legal leaders knew considerably fewer ex-patients, being presumably less called upon to deal with them in the course of their work.

Dohrenwend concluded that the contrasting values held by the different groups led to their differing ways in organising their experiences of deviant behaviour and appraising it.

Empolyers' Attitudes

Among those who have explored employers' reactions to ex-mental patients are Margolin (1961), Landy and Griffith (1958), Olshansky, Grob and Malamud (1958), Linder and Landy (1958) and Askenasy/

Askenasy and Zavalloni (1963).

Olshansky and Grob reported that prospective employers were much concerned about the possibility of violence on the part of ex-patients and were also worried about the illness recurring. Employers would avoid telling fellow workers about the past history of the new employee, ostensibly in case they might become upset, might act cruelly to the patient or, in the other extreme, be embarrassingly helpful.

Workers asked the same question mostly seemed willing to work alongside an ex-patient but were also of the opinion that it would be best for his case to be kept quiet. The reason given by one worker is interesting as it ties up very closely with what Goffman discusses in Stigma (1963).

The workman said, "It would come back to the fellow and he'd feel on the spot as if everybody were looking at him. It would be the same for an ex-convict --- if something is missing, everyone looks at him".

This is precisely the situation which Goffman skilfully analyses at very great length. He describes how the person who is deviant or abnormal in some way is never accepted for themselves but is constantly perceived by others in terms of the image or role which has been imposed upon them by virtue of their disability.

Olshansky et al. could find little evidence of actual experience of the mentally ill among Boston employers. This they took to be partly/

partly due to deliberate avoidance on the part of business men, and partly due to the tacit understanding that concealment would be to all employees' advantage.

Landy and Griffith also working in Boston, found positive reluctance on the part of social workers in America to offer assistance in job seeking to ex-mental patients. They are expected to stand on their own feet and virtually no attempts have been made to persuade employers to hire such people.

The authors approached fifty local employers with a positive proposal of this kind and got encouraging responses. More than three quarters of the employers were sympathetic, and subsequent attempts at placing actual patients with them were moderately successful. However the numbers were too small for proper analysis.

Margolin carried out a survey of employers' reactions to known former mental patients working in their firms. He questioned the employers regarding the suitability of the patients for the jobs to which they had been allocated and found that there was great scope for careful rehabilitation and matching of patients to particular positions.

In advocating such common sense measures, Margolin had to advance sound economic reasons as well as pure philanthropy. He pointed out that man-power was meanwhile being wasted, and that these ex-patients were people who could often be relied upon to work conscientiously for sympathetic employers.

Since/

Since the survey carried out by Askenasy and Zavalloni has implications for members of the wider community and not only for employers, discussion of its underlying hypotheses, methods and results will be left until later. It was a "cross cultural" survey, including Oxford and Hawaii as well as America.

The Attitudes of General Practitioners

Most of the studies relating to general practitioners' attitudes which will be referred to presently have been done in Britain. But Mary Lemkau (1962) interviewed eighteen general practitioners in Carroll County, Maryland at the same time as studying community attitudes to mental patients' care.[6] The questions related to their experience of arranging hospitalization for mental patients, to their undergraduate training in psychiatry and to their estimate of recent changes in public attitude towards the mentally ill. However, since Mary Lemkau's aim was mainly to assess the acceptability of a new plan for psychiatric care proposed by the Health Department, her findings are of merely local interest.

An article by Kessel and Shepherd in 1962 on the neuroses in hospital and general practice dramatically revealed the state of epidemiological confusion arising from differences of definition. Kessel and Shepherd laid the blame for this state of affairs not only on/

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6 See Chapter IV.

on the ill-defined boundaries of the categories which could comprise neurosis but also on the involvement of the individual doctors' point of view. The doctors' varying interest in and knowledge of psychiatric disturbances had given rise to estimates of psychiatric morbidity ranging from below ten per cent to over fifty per cent.[7] The same point has been made by Shepherd *et al.* (1959; 1964), by Cooper *et al.* (1962), by Ryle (1960), by Reid (1960) and in the W.H.O. Technical Report on the Epidemiology of Mental Disorders (1960).

The latter publication lists some variables which influence psychiatric diagnosis, namely, the attitude of the community to unusual behaviour; prevailing opinions about the value of psychiatric care; the nature and quality of the available facilities; the social background of the psychiatrist; differences in the approach of individual general practitioners and differences between the G.P. and the psychiatrist; and finally, the wide variations in human character and behaviour.

The anonymous W.H.O. writers pose the vital question of what should be the cut off point for the psychiatrist's field of operation,[8] without/

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7 The authors also pointed out the confusions arising from different bases being used in the calculation of percentages. This article provides a very useful bibliography.

8 See also Kessel on "Who ought to see a Psychiatrist" (1963), and Forrest, A.D. (1967) on "Can we afford mental health?"

without presuming to provide the answer to it.

The study by Rawnsley and Loudon (1962a; 1962b) in a South Wales mining valley set out specifically to examine the factors influencing the referral of patients to psychiatrists by general practitioners. Eight G.P's who were operating in six separate practices were interviewed with a view to discovering their attitudes to and opinions about the local mental health services; their own methods of treating and referring psychiatric cases; the recent changes in frequency of various types of mental disorder; and the causes of mental illness.

This part of the data was then compared with information regarding the patients who had been referred from these practices to psychiatrists over a period of nine years.

The authors concluded that differences in the doctors' referral rates were related to social and attitudinal factors. Doctors often seemed to be making the decision to refer a patient on account of pressure from the patient himself or from his relatives, or because of "non-clinical" factors in the situation. The authors ended by remarking, "Referral will depend in part upon the attitudes prevailing in the population to illness, to doctors in general and to psychiatrists in particular. There may well be variations in such attitudes which are related to sex, age, social class, area of residence and other factors".

Similar/

Similar conclusions were reached by Mowbray et al. (1961) after analysing letters sent by G.P's when referring patients for psychiatric advice. The topics mentioned often included social problems, though conduct abnormalities and failure to respond to treatment were also stressed. They considered that varying attitudes on the parts of G.P's were influencing the number and type of referrals.

Cooper (1964) reported on the results of sending a lengthy postal questionnaire to G.P's enquiring into their opinions and attitudes in this field and trying to validate the results against available morbidity data from the practices concerned. These doctors seemed to be overestimating the actual number of neurotics in their practices, possibly revealing thereby their dislike of this particular group of patients. The doctors showed a wide range of beliefs regarding the part played in various illnesses by psychogenic factors.

Recently Rawnsley (1966) has reported on a further approach to the question of the G.P's point of view in a carefully designed study to compare psychiatric morbidity and attitudes to symptoms. For the purpose of the survey the population was divided into special groups with differing social characteristics and did not follow the Registrar General's Classification. Estimates of morbidity based on the Cornell Medical Index Questionnaire and on the judgements of general practitioners varied between social sections and this variation could/

could not be explained by differences in the frequency of contact with G.P's nor by people's alleged willingness to consult their doctors for relief of sundry symptoms. Rawnsley considered that it might depend upon the G.P's differential perception of psychiatric disorder among members of the various social sections.[9]

He made the point that it would not be fruitful to persist in seeking for "true" prevalence rates for psychiatric disorders. The question should rather be, "For any given measure of differential prevalence, what factors, including those inherent to the instrument used, influence the results?"

By acknowledging that reactions between observer and observed are inevitable and mutually influential in any human encounter, Rawnsley has shown a good deal more sociological sense than most other writers on this subject who have mainly been content to deplore the present situation and vainly to anticipate a bright new future when all men, public and "experts" will think alike.

Myers (1955) reported on a poll of 405 non-psychiatric physicians which showed that younger doctors were better informed regarding mental illness and psychiatric matters generally than their elders. He thought that this was probably related to the changing content of medical education.

The Development of Medical Students' Attitudes

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9 This recalls the previously mentioned work of Zola (p. 25).

As far as medical education is concerned, Walton (1963; 1964; 1966) and his colleagues have, for some years, been following the interests of Edinburgh medical students.

Using a variety of measures they have separated different types of medical students. The two main divisions are into those who are organically orientated, and those who are interested in the psychological or social aspects of patients. But within each of these groups there are two further sub-divisions.

The first type whose personality could be derived from the evidence on medical students is the organically orientated doctor. He is generally "adequate" in his dealings with patients, even although he may have a narrow, physical approach. The second is "limited", showing actual dislike of patients who have no serious organic illness.

The remaining two types, although both interested in the social aspects of illness, varied as to whether they were predominantly "research orientated" or "patient centred".

The investigation of medical students' attitudes[10] does seem a convenient means of arriving at the views of future doctors in practice. Whilst there is not much that can be done to change the outlook/

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10 There have been many such studies in the United States. Examples are to be found in the work of Moos and Yalom (1966) (who also supply a comprehensive bibliography), Saslow and Mensh (1953), Watts and Davis (1960) and Altrocchi and Eisdorfer (1961).

outlook and methods of present-day doctors, those of the future can presumably be influenced by the type of undergraduate training which they receive.

Lately Rawnsley and his colleagues (1967)[11] have also been studying groups of students in Wales, under guise of discovering, "Attitudes to public and private responsibility". The specially designed questionnaire employed a number of descriptions of people's behaviour in various circumstances. Some of the behaviour would be judged by a psychiatrist to be symptomatic of mental disorder, but three of the vignettes dealt with essentially normal activities and in no case was a specific label of mental illness given. In each instance the actor's social status, age and sex were indicated. The students were asked to judge, firstly, whether anything was amiss and secondly, whether any help or advice from some person or agency was deemed necessary.

The above mentioned section of the questionnaire was answered by students in many faculties. In addition, medical students completed a section concerned with their concept of their own role in dealing with physical and psychiatric disorders.

Rawnsley and his co-workers uncovered differences among students both in respect of their assessment of deviance and in their evaluation of the need for help. For example, Baptist theological students/

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11 Personal communication.

students had a wide concept of abnormal behaviour, to deal with which they recommended calling in the clergy; engineering students seemed very self-sufficient; social science students were less inclined to advocate self-help and encouraged psychiatric consultation.

On the whole, the medical students regarded psychiatric patients and particularly neurotics, as being inappropriate objects of medical care and they were quite prepared to recommend the alternative advice of psychologists and clergy in many instances.

The discovery of considerable variations in attitudes towards deviant behaviour amongst a group of people as comparatively homogeneous as university students suggested that sections of the general population would be likely to display even wider differences in attitudes and reactions to abnormal behaviour. But before proceeding to consider the attitudes of the community at large, or of separate communities, it will first be necessary to look at the mental patient's closest associates, his own immediate relatives.

CHAPTER III

REVIEW OF THE LITERATURE (CONTD.)

THE FAMILY'S REACTION TO MENTAL ILLNESS

The attitudes towards mental illness felt by a family which has an affected member are likely to be different, both in type and intensity, from those of the relatively uninvolved members of society at large. Of all the various social networks to which an individual belongs, the family is the most intimate and it is among the immediate family that the first impact of abnormal or unusual behaviour will be felt. The subsequent attitudes which relatives adopt will be subject to wide variations, depending primarily upon the nature and closeness of the relationship in question, but also upon a great many other factors.

The availability and accessibility of relatives of mental patients has naturally led to their selection as the centre of a number of studies. The concern felt by close relatives when a patient has to be admitted to a mental hospital makes them easy subjects for all manner of interrogations and there is usually no difficulty in persuading them to detail the events which led up to hospitalisation. Similarly, at a later stage, the prospect of discharge affords a convenient opportunity for the exploration of/

of relatives' feelings regarding its feasibility from their point of view.

American Studies

As in so many other areas of medical sociology, the majority of studies have come from America. These will be dealt with first, before coming to the British surveys which are of more immediate relevance in view of the differences in social structure and in the medical services in Britain.

A well known example of an admirable and exhaustive study has been the investigation of Clausen and his colleagues (1955), called "The Impact of Mental Illness on the Family", which traces in detail many of the aspects which go to make up the total impact of mental illness.[1] These workers have described in a series of articles the multiplicity of distracting events and the various sorts of advice and pressure to which a wife is subjected before hospitalisation of her husband takes place, as well as detailing the complexities of her solitary existence, and her own personal conception of her role during the period of her husband's confinement to an institution.

Subsequently, Charlotte Schwartz (1957), a member of the same team, made a sympathetic analysis of the reactions of the wives of psychotic patients to their husband's deviant behaviour - reactions characterised/

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1 Based upon thirty three male first admissions to mental hospital.

characterised by a tendency to normalise eccentricities for an amazingly long time.

Freeman and Simmons (1961a; 1961b; 1961c) have contemplated the attitudes towards mental illness among relatives of former patients and also the feeling of stigma which the relatives experienced. They used short, structured scales for the assessment of attitudes towards the mental hospital, the aetiology of mental illness, the normalcy of former mental patients and the responsibility of the patients for their condition. The authors found that attitudes were associated with education, age and what they called "verbal ability", but they could show no relationship between these attitudes and social class measured independently of education. Commenting on this finding, they considered that so-called "enlightened attitudes" could be better accounted for on the basis of different verbal skills[2] than on differences in the "styles of life" of separate social classes.

Not surprisingly, relatives' attitudes were also found to be associated with the actual behaviour of the discharged patients.

Muriel Hammer (1963) made a valiant effort to apply statistical techniques to the circumstances attending the admission of fifty-five Negro and Jewish male psychotics to a New York mental hospital. She hypothesised that the speed with which hospitalisation would be sought by relatives would depend upon three factors. Firstly,/

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2 Estaimated by scores on a vocabulary test.

Firstly, if the relationship was a close and direct one (such as husband - wife) and particularly if it was a symmetrical relationship (i.e. when the two persons involved had no other relationship which was closer), she expected either an early move to alter the patient's behaviour, by treatment or hospitalisation, or else that the relatives would alter their own behaviour so as to minimise the impact upon the relationship. Secondly, she expected that in interconnected family social units, where a number of other people could absorb the burden of responsibility caused by the patient's defection, hospitalisation would be slower and there would also be less danger of a complete severance of the primary relationship between the patient and his closest family member. Thirdly, she thought that if a patient's behaviour was essential or critical to the maintenance of the family as a unit, there would be little room for variation in the performance of his customary tasks, and any minor alterations would be likely to lead to early hospitalisation.

She found in fact that there were certain types of disturbed behaviour which led to very prompt action in any circumstances. If there were active immediate threats to life or property, in other words, violence, emergency measures were always taken to have the culprit promptly removed from the scene of his operations. Hospitalisation might be initiated by all sorts of people as well as relatives - e.g. neighbours, employers, etc. - the police were often called in to effect the move.

There/

There were, however, many instances of behaviour which was much less dramatic, characterised by withdrawal from action rather than over-activity. Such behaviour was only disturbing to people who had close ties with the patient, and the point at which they sought hospitalisation did depend upon how critical the patient's position was in the household.

In symmetrical relationships she did not find the expected rush to obtain hospital care, though the close relative did provide help and personal care and often tried for some time to interpret the patient's altered behaviour in an acceptable fashion. This bears out Charlotte Schwartz's work.

Sampson, Messinger and Towne (1962) studied an even smaller group in a rather similar effort to understand: "How individuals and the intimate social networks of which they are members are rendered less and more accessible to institutionalised devices of social control". The subjects were seventeen families in which the wife-mother had come to be hospitalised for the first time in a state mental hospital with a diagnosis of schizophrenia. They thought that they could discern two main patterns of behaviour.

The first they called, "the uninvolved husband and separate worlds". The phrase is very expressive of the situation, where the husband simply ignored his wife's increasing symptoms and withdrew from her. This might mean that a long time elapsed before an acute crisis, characterised by sudden excess demands made upon the wife or a sudden lowering of her husband's tolerance, precipitated hospital/

hospital admission.

In the second pattern, the authors noted the presence of an overbearing and interfering mother-in-law who took over her daughter's domestic tasks. She was very involved in the situation between the couple, who alternately resented her and relied upon her. A crisis was liable to occur when the daughter eventually revolted against her mother but was unable to re-establish relations with her husband. Hospital broke the bonds of the triangle and afforded an escape route for the desperate patient.

Though these two "patterns" are interesting, they can scarcely be generalised to apply to all cases of incipient psychotic illness in a wife, which is bound to provoke differing reactions depending upon the personality of the spouse, the wife's own customary degree of responsibility and control within the household and the conflicting claims and advice of children, to name only a few other variables.

In considering agents, timing and events leading to mental hospitalisation, Linn (1961) reviewed a much larger series of 582 psychotic first admissions.

His findings were rather similar to those of Hammer, symptoms of withdrawal were late in receiving attention, families reacted to the totality of symptoms, and patients who were living with a spouse or with parents were more likely to be hospitalised than those living with more distant relatives.

He/

He noted that a spouse or parent had greater social permission to interfere in the life of, or to direct adult women than adult men. But a male patient who had lost his job was more likely to be hospitalised than one who, through continuing in employment, seemed to be giving evidence of moderately adequate performance.

Rose (1959) interviewed a group of relatives who visited 100 patients in a Veterans Administration Hospital. He found that the mother was the most faithful visitor.[3] Other relatives gave various reasons for coming, a sense of duty, a fear of criticism by other members of the family, continuing guilt at their responsibility for hospitalisation. Relatives seemed moderately satisfied with the psychiatric treatment the patient was receiving, although they professed to be unable to understand it, but were critical of certain aspects of his physical care, his feeding and the like. Their attitudes to the personnel were largely negative (a reaction which Rose assumed was born of resentment towards "parental surrogates", but which might equally well have been in response to their own treatment by the staff). They persisted in seeking imaginary physical causes for the patient's condition and were reluctant to think in terms of psychological factors. Although many relatives expressed only qualified enthusiasm for the suggestion that the patient should return home, there/

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3 Most of these patients were single.

there were some mothers who wanted their sons home under any circumstances. On the whole the relatives felt cut off from the hospital and its routine, it seemed to them primarily custodial, protecting them from the task of coping personally with the patient's vagaries.

The distance which lower class families feel when confronted with "superior" psychiatric personnel has been brought out in great detail in Myers and Robert's book, 'Family and Class Dynamics in Mental Illness' (1959). This is a very comprehensive study which explores all the interconnections between social class and mental illness in New Haven and is a sequel to the work of Hollingshead and Redlich, which was mentioned in the previous chapter.

They set out to explore the hypothesis that all these factors would be related to the class structure, namely, the prevalence of treated mental illness; the types of diagnosed psychiatric disorders; the kind of psychiatric treatment administered by psychiatrists; the influence of social and psychodynamic factors in the development of psychiatric disorders. They were also of the opinion that mobility in the class structure was associated with the development of psychiatric difficulties.

The subjects of the study were white adults from two non-adjacent classes, III and V and were all either schizophrenic or psychoneurotic cases.

They did find significant differences between the two social classes/

classes of patients in respect of their role relationships within the family, the way in which their sex roles developed, the extent to which they felt external community pressures and also in respect of their attitudes towards psychiatric illness in all its aspects. The findings regarding the possible effects of striving after mobility were less clear, however.

The authors admitted the limitations inherent in their selected case material, but their discussion on the nature of the many and varied stresses in the American middle and working classes make fascinating reading. Since their study suffers from the deficiency of having been quite uncontrolled it is, however, debatable whether their findings are generally applicable or could take the place of a sociological study in the community. Some of their statements are certainly rather sweeping, for example, "There was more warmth and affection during childhood in the homes of Class III than Class V patients". It may be that some of the prejudice which the authors were at such pains to expose has crept occasionally into their own judgements. But they have made a careful and valuable contribution to the study of the impact of mental illness in treated patients from these two classes and have dealt clearly with the differing symptomatology, reactions to symptoms and responses to treatment which the two groups displayed.

Kathleen Smith and Muriel Pumphrey (1963) focussed specifically on/

on the pre-hospital crisis which forces a family to take action. Their subjects were two groups of schizophrenics whose relatives were interviewed shortly after the patients' admission. They were not all first hospitalisations.

Suicidal attempts and actual harm to others were tolerated by none. The community sought the removal of obscene, noisy and nude patients, but disregarded minor oddities of speech or behaviour.

The authors drew attention to the discrepancies between the conditions leading to a clear perception of physical illness and the very severe impairment of activity which might be permitted to a person before his family recognised him as mentally ill. Families, for example, would tolerate nudity and obscenity, provided it occurred at home. Violence, or the threat of violence did, however, prove "the last straw". Only four per cent of the patients in this study had themselves requested admission to hospital.

Wood et al. (1960) studied a group of forty-eight patients with various diagnoses in a Veterans Administration Hospital in the attempt to make some order out of the chaos surrounding their admission. It turned out that the majority of these patients had themselves decided to seek hospital care. They came specifically to obtain relief from pressing symptoms, generally of a physical nature, and the idea of psychological aid did not seem to have occurred/

occurred to them. To many the hospital was a refuge from difficulties at home or in other areas of their lives.

The smaller group (27 per cent), whose relatives had initiated the decision to seek help, came from families where several people had participated in this joint decision. It had often been phrased as a threat, that the patient must either obtain treatment or get out. These patients stayed in hospital for a significantly shorter time than did the ones who had come in of their own accord.

Unfortunately this well-intentioned study suffers, like so many others, from its small size and the ill-assorted sub-groups of which it was composed. But it is interesting on account of the absence of any specific references to violent behaviour and "crisis" situations.

Warner (1961), concerned at the haphazard way in which decisions to take mental patients to hospital against their will were generally being made, set out to codify the criteria which ought to guide a Public Health psychiatrist in this predicament. His conclusions are only of marginal interest in the British context, but two of his incidental observations certainly deserve recording. He states:

"We have observed distinct cultural variations within the larger community. Thus the ability of the family or friends to help or tolerate the patient depends not only on the patient's premorbid/

premorbid role in the family and community but also on the prevailing attitude towards responsibility to the mentally ill. Some ethnic groups have a desire, 'to take care of their own' and show a reluctance to allow relatives to enter a hospital ..... except for severe physical illness. These groups generally live close together in cohesive family units and excuse mental illness as 'eccentricity' or as a transient behaviour aberration. The aged are given high status and protection and care when needed in these families .....

"We have been amazed at the amount of psychopathology the community can tolerate. It seems as though individuals have remained mentally ill in the community for long periods of time once an equilibrium has developed within which their minimal needs can be met. This is especially true if these individuals are quiet, not dangerous to others, and do not make any demands on unwilling parties".

Quite apart from the comparatively optimistic picture which is portrayed, such lucid prose is a refreshing change from the jargon favoured by so many American sociologists.

The person who has actually been a mental patient tends, as was suggested in Chapter I, to bear thereafter a label which clearly marks him out in the eyes of society. The question of the reception of such a person is a different one from the matter of his initial assignation to the role, and it has received a fair amount/

amount of attention both in America and in Britain.

Only two of the American studies will be mentioned here. These are chosen because they raise an interesting point regarding the interpretation to be put upon a particular correlation.

Freeman and Simmons (1961), whose work has already been mentioned, found a strong association between normality of behaviour and the performance levels of former mental patients. They found in fact that patients who were working and behaving well were living in families which had a low threshold of tolerance for deviant behaviour, whilst patients whose behaviour was more abnormal were situated in families with lower expectations of performance.

They concluded, "A strong association was found between the performance levels of patients and reports of their relatives regarding abnormal behaviour ..... Level of social integration is correlated with the type of family in which the patient resides, personality characteristics of female members, and the expectations of these members ..... These results ..... strengthen the likelihood that differential tolerance of deviance, on the part of family members, is a critical factor in the course of post-hospital experience of mental patients".

Pasamanick and his colleagues (Dinitz, Angrist, Lefton and Pasamanick, 1959) took up this question of the differential tolerance of deviance by different societies and in different families. They hypothesised/

hypothesised that this variable would make a difference to patients' post-hospital performance and ability to avoid re-admittion, and they set out to test their hypothesis by studying 287 female patients six months after discharge from hospital.

Their predictions were supported by the evidence: women who were low performers were living with highly tolerant people who, however, predicted eventual re-admission, whereas women who performance was high were with relatives who did not anticipate re-admission but would contemplate it on the appearance of fewer symptoms.

Pasamanick and his team found that when patients did have to be re-admitted it was on account of episodes of extreme and unmanageable behaviour, such as homicidal or suicidal attempts. The re-admitted patient, they were bound to concede, was clearly sicker, so possibly her "significant other person" was only tolerant until her symptoms became acute and unmanageable.

They drew attention to the two separate interpretations which could follow from the inter-relation between tolerance and performance. On the one hand, it could be argued that the patients were living up to their relative's expectations. (This is Thomas' "Definition of the situation", once again). But the findings could equally well reflect the patient's actual condition and ability to perform, which was determining the relative's reaction.

This/

This paper is a very important one because it has demonstrated how two quite different conclusions may be drawn from the same sort of statistical evidence, conclusions which have widely differing implications for practice.

On the one hand there is the Parsonian view that many Americans have a low threshold oftolerance for deviant behaviour and are more and more inclined to pack their erring members off to hospital at the first sign of "impaired role or task performance". But if, on the other hand, families in fact adapt themselves to the situation as they find it and learn to re-organise their lives around the minor abnormalities and eccentricities of some of their members, the prospects for the care of the mentally ill in the community are vastly different. And on this note, it now seems appropriate to turn attention to the British scene.

British Studies

Although it may have no statistical significance, it is at least worthy of note that so many women sociologists have concerned themselves with the plight of the mental patient and his reception by society at the different stages of his "career".

Enid Mills did the work for her book 'Living with Mental Illness' (1962) before the implementation of the new Mental Health Act.[4]

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4 Her analysis of the deficiencies in the administration of the Mental Health Services will not be treated here.

Act. This was based upon a survey in an East London borough on seventy-six patients admitted to Long Grove Hospital, Epsom. On the basis of information obtained through interviews with the patients and seventy-four relatives, she explored the events which had led up to hospitalisation and the attitudes and reactions of the central figures to the patient's illness and admission. She also went into the reasons which lay behind some patients' sudden decision to take their own discharge, and how the patient and his relatives reacted to the whole hospital milieu, including the staff and treatment.

Although she attempted some elementary analysis of the patients in terms of their age, sex and marital status in relation to their length of stay in hospital, the total numbers were too small for definite conclusions, and the main value of her work lies in her understanding of the difficulties which faced the patients and his relatives when confronted with a treatment situation which did not make sense to them and which failed to conform to their own rather vague expectations. The situation was exacerbated for many families because the distance of the hospital from their London homes made regular visits very awkward to arrange.

Pat Patten's work on mental patients and their families in Belfast has already been commended (p. 27). She took the sensible step of providing a matched control group of patients with/

with heart disease to compare with her psychiatric cases. She found more distress in the families of psychiatric patients than in the families of physically ill patients, largely due, she considered, to the family's failure to structure the situation satisfactorily.

In a second study (1963) she interviewed families of patients on their first admission to a short stay psychiatric unit of a general hospital. The interviews took place during the patient's stay and upon discharge. She distinguished two groups of patients and relatives, the first were mainly instances of depressive illness, who had been previously treated for this condition by their G.P's and who were to have E.C.T. They were mostly unskilled workers who had received a minimal education and neither they nor their relatives expected anything more than physical treatments. Considerations of personality problems could not interest them as the families concerned had already settled for accepting one another in their unredeemed state with all their imperfections and personal peculiarities.

The other group, where the patients were mainly psychoneurotics, were in considerably more confusion. In their case a minimal knowledge of modern psychological concepts was mixed with many ideas carried over from physical medicine and from morality. They could not understand the processes which had determined the necessity for admission, the rationale of psychotherapy, or the undue length of stay in hospital, and they felt/

felt disappointed and at a disadvantage on the rare occasions when they did manage to secure an interview with a doctor. Doctor and relative[5] usually failed to make effective contact, neither understood the other's point of view or could usefully discuss what seemed to them important.

Patten's careful examination of all the facets of the relatives' quandary is made from a pragmatic standpoint which concedes little to psychoanalysis. She has shown herself peculiarly sensitive to the real difficulties and differences which the process of psychiatric illness raises for its main participants and the multiple sources of possible misunderstanding between "experts" and the lay public.

Most British studies score over their American counterparts in being more systematic, better controlled and in having certain limited practical ends in view.

Folkard et al. (1962) looked not only at groups of schizophrenics and neurotics living in the community, but also at normal subjects when they enquired into the extent and nature of the problems[6] which they experienced.

Their findings were complicated, but the main interest in their research project lay in their discovery that some personal problems were characteristic of more than one clinical condition and/

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5 Patten did note, however, that relatives who felt themselves to be the doctor's equal had no difficulty in obtaining interviews and found communication much easier.

6 Using the Mooney Problem Check List.

and even of normal individuals. As the authors state:

"In attempting to assess the extent to which particular personal problems are associated with mental disturbance, it is important to know the prevalence of these problems in the general population and how often they occur in normal people".

A great deal of the careful investigation which has gone on into the family circumstances and emotional background of prospective or ex-mental patients has been rendered virtually useless by the absence of this elementary precaution.

Folkard (1960) has also studied comparative attitudes to the rehabilitation of psychiatric patients. He interviewed eighty five patients who had been in a mental hospital for at least two years and who were selected for a programme of rehabilitation and compared their answers to a questionnaire on attitudes towards life and work outside hospital with the views of their key relatives on the same subject. At the same time Folkard obtained the views of staff members regarding the patients' social prognosis.

Most patients tended to have a higher opinion of their own capabilities and prospects than did their relatives, although there were some who were positively disinclined to leave the shelter of the institution.

The relatives' pessimism was, on the whole, not justified in practice, the patients themselves and the staff giving estimates which were more closely related to subsequent performance.

Rawnsley/

Rawnsley, Loudon and Mills (1962) in South Wales also studied the attitudes of relatives to patients in mental hospitals, taking into account the assessment of the staff as well.

They found that, whilst the amount of active interest shown by the relatives was correlated with the patient's length of stay in hospital, it was not related to the patient's age. Married patients seemed to retain their relatives' interest better than single patients.

Contrary to Folkard's findings, Rawnsley et al. found that staff and relatives were in significant agreement over the patients' capacities for life outside.

Relatives as a whole were far from disinclined to have the patients back home, 60 per cent of all patients and 24 per cent of those who had not had a visitor for a year were assured of accommodation[7] once they were discharged.

There have been several other studies dealing with different aspects of rehabilitation and the adaptation of families towards the return of the ex-mental patient. But since this is a fairly specialised section of the subject it will not be reviewed here. Instead, the next chapter will leave the intimate family setting in order to focus upon the conceptions of mental illness and the mentally ill which are held by the wider community and which have been investigated, with somewhat contradictory results, in both the United States and Britain.

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7 A recent report by Lowther and Williamson (1966) is of interest in showing how ready relatives of geriatric patients are to receive them home.

CHAPTER IV

REVIEW OF THE LITERATURE (CONTD).

STUDIES OF COMMUNITY ATTITUDES TO MENTAL ILLNESS

In the last three chapters the concept of mental illness has been gradually tracked down from the broad dimensions of sociological theory, through the views of various special groups, to the experiences of intimate family units.

This narrowing down of particular conceptions has been based upon the assumption that people who are in close touch with the mentally ill will have developed more clear and precise notions as a result of their experience. And the coincidence of the ideas of the general public and of the psychiatrists and their associates has been taken for granted as a desirable end, to be encouraged, if necessary, by suitable mental health education.

But there are other methods of arriving at an appreciation of community stereotypes of mental illness than psychiatric or sociological speculation or the close examination of the circumstances surrounding individual instances of mental disorder, and/

and there have in fact been a large number of surveys[1] carried out in different communities both in Britain and in America.

First initiated about twenty-five years ago, they started as small studies of indifferent design which were shortly to be followed by more ambitious projects. Finally, over the last five or six years, attention has been focussed upon certain special facets of community attitudes in this field and upon some of the possible overall conclusions which can be drawn from the findings of the different research teams.

Once again, the more numerous American studies will be treated first, before reviewing several British surveys which relate to the more immediate situation.

Early American Studies

In 1943 Allen reported on what appears to have been one of the earliest of these studies in the general population by interviewing a modest sample of the "leadership group" in Dallas, Texas. It was rather hastily devised, framed principally to show/

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1 Silverman (1958) has published a very useful working paper on "Studying attitudes towards mental health", Dunham (1962) has specified rather narrowly some of the uses of sociology in the investigation of mental illness, whilst Felix and Clausen (1953) considered the role of surveys in advancing knowledge in the mental health field, as a prelude to their own studies of the "paths to the mental hospital".

show what the term "mental hygiene"[2] meant to various individuals and what they regarded as local priorities in the field of mental health. It turned out that many people in Dallas in 1941 were rather confused on these matters; thus a prominant churchman remarked, "Psychiatry and education too, should be linked up with the divine and the eternal", whilst a number of citizens thought, understandably enough, that the term "mental hygiene" meant "having clean thoughts".

Ramsay and Seipp (1948) reported on the opinions and information concerning mental health which prevailed in Trenton, New Jersey, among a sample of 345 people over the age of eighteen. This was also an extremely simple type of poll, consisting of six questions[3].

They/

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2 This is still a very vague concept. Lately the World Federation of Mental Health proferred the following definition of the aim of mental health action: "To help men to live with their anxieties in a changing world", Soddy and Ahrenfeldt, 1966.

3 The six questions were:

1. Have you any ideas why people go insane (crazy)?
2. (a) If someone you knew began to show signs of very strange or odd behaviour, do you believe anything could be done to help?
   (b) What do you feel should be done?
3. Do you believe that insanity is God's punishment for some sin or wrongdoing?
4. Do you or do you not think that insanity is inherited?
5. Do you or do you not believe that people who are around those who are insane tend to become odd or strange themselves?
6. Some people believe that poor living conditions are a cause of insanity. Others disagree. What is your opinion?

They uncovered what they chose to call, "More enlightened opinions" among the better educated and the higher occupational classes. Answers from the better educated and from women were more likely to refer to emotional and psychological factors in the causation of mental illness, whilst people with less education stressed alcoholism, overeating and overwork. It also appeared that respondents from the better educated and higher social classes were more optimistic about the prospects of cure for mental illness and would be more inclined to recommend professional help for a case. They would be less inclined to connect "sin" with insanity, or to think it would be harmful to associate with the insane.

Freeman's work has already been mentioned. The survey which he carried out with Kassebaum (1960) in Washington State[4] during 1950 suggested that "opinions regarding the aetiology and prevention of mental illness are only slightly, if at all, related to the level of formal education". They doubted whether peoples' opinions on mental illness could be modified by merely supplying "facts", unless at the same time an effort was made to understand "the frames of reference by which persons integrate factual information and personal opinion". This work, then, contradicted Ramsay and Seipp's correlation of education with level of "correct" information on mental illness.

From/

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4 Interviews were carried out on a sample of 438 adults.

From Louisville, Kentucky, Woodward (1951) reported on the result of a survey carried out there the previous year by a commercial firm of market researchers.[5] A much larger sample was chosen here than in the two previous ones (3,971 people over eighteen) and fairly lengthy interviews were involved.

Most people looked upon mental illness as a sickness. The younger and better educated people had the most "scientific" and humane outlook. There was a tendency for respondents to recommend seeking help from family, friends, clergymen or their own doctor rather than from a psychiatrist, in the case of a variety of hypothetical problem situations. For example, in response to the description of a depressed man who had lost his job and attempted suicide, one third of the whole sample recommended a good talking to by his family and friends in preference to any kind of medical, restorative or psychiatric care. And less than one third would recognise mental illness in the description of a wife who threatened to kill a neighbour with whom she imagined her husband was having an affair.

The Louisville study also used descriptions of a schizophrenic girl and a delinquent youth.

This survey was extended to a separate sample of professional groups in the community and the results showed a marked difference between lawyers and the rest, consisting of doctors, teachers and clergymen./

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5 Elmo Roper.

clergymen. The lawyers were more punitive, resisted the suggestion that psychiatrists could help with emotional problems, and thought that mental illness in the family should be kept secret.

Redlich's work in Yale (in collaboration with Hollingshead) was mentioned in the last chapter. In addition to his work on social class and mental illness he has also investigated the meaning which certain medical terms have for the lay public (1949), and made an endeavour to uncover community attitudes. (1950). In the attitude study he used as subjects the members of an extra-mural class at the University (104 men, 646 women). Most of the class were students and students' wives and they were asked questions regarding the psychiatric treatment, the causes of behaviour disorder and the nature of psychotherapy.

As well as posing straight questions, the schedule which Redlich used contained sentence completion tests, relating to the work and characteristics of psychiatrists. These yielded some interesting comments on the supposed powers and peculiarities of the profession, such as, "Psychiatrists are able to direct your mind" and "Psychiatrists are interesting and morbid".

The students were vague about the professional qualifications of psychiatrists and psychologists. But most had accepted the dictum that, "Psychiatrists are working with people who are emotionally upset".

Redlich/

Redlich said, significantly, "It is not the 'insane' patient any more who in the popular mind is the principal object of the psychiatrist's diagnostic and therapeutic effort".

However, Redlich was emphatically not probing "the popular mind" in this survey but rather the minds of a very specialised group of highly educated people whose prior interest in psychiatry had been attested by their presence in his class.[6]

Redlich found many of the attitudes of even this highly selected group to be distinctly disappointing. "The public", he concluded sadly, "has strong and often negative feelings about psuchiatrists: they are often thought of as aggressive, un-necessarily curious, too much concerned with money, at times in possession of sinister power to read minds and influence fate and quite often as abnormal as their patients".

About this time, in the early fifties, Zimbalist (1951, 1952) employed students in Washington University, Saint Louis, Missouri to carry out two surveys into opinions about mental illness.

In the first survey he aimed at an area sample of 388 heads of households and succeeded in obtaining interviews from 285 of the chosen respondents, three quarters of whom were women.[7]

Zimbalist/

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6 But his observation is not without significance as it does point the difference in the outlook of young, educated, middle class people, who think in terms of "problems" and "analysis" and members of less fortunate groups who have perforce still to associate psychiatrists with "insanity" or psychosis.

7 But he found no significant difference in opinions between the sexes.

Zimbalist was clearly aware of the difficulty of determining the frame of reference from which a respondent would present his ideas on this subject. He drew attention to the importance of this semantic problem and proposed to circumvent it (as Woodward had done) by presenting thumbnail sketches of cases. These were intended to represent "aggressive psychotic behaviour", "withdrawn psychotic behaviour" and "neurotic behaviour". Zimbalist acknowledged that such vignettes could only inadequately represent for anyone the complex behaviour patterns of the mentally ill, but he hoped to use them to obtain relative figures for the recognition of mental disorder by different groups in the community.

After being presented with the three descriptions, respondents were asked directly whether they considered them a form of mental illness, what they thought had caused it, whether the person might improve, and how.

It is important to note that the respondents in this survey were being explicitly asked about the possible association of particular behaviour with mental illness, whereas in the Louisville survey by Woodward the suggestion of possible mental illness as an explanation for certain actions had to come from the respondent.

Nearly three-fourths of the St. Louis sample saw definite mental illness in the "aggressive psychopath", somewhat over one half/

half did so in the "withdrawn psychotic" and one seventh for the "neurotic".

With regard to causation, most people sought for explanations in the environment and did not stress heredity. The idea of mental illness as a punishment for sin seemed to be totally outmoded. However, there was a large group who attributed mental illness to personality characteristics and who seemed to imply that the individual in question was in some sense "responsible" for his own predicament.

Sixty-four per cent recommended professional treatment for the aggressive psychopath, but such care was much less likely to be recommended for the other two "cases".

Zimbalist's team enquired into attitudes as well as into matters of information and understanding. They found that more than one third of the respondents would advise someone attending a psychiatric clinic to avoid telling people about his position.

They also questioned respondents about their reactions to an ex-mental patient in respect of certain degrees of social interaction or distance. In this connection, ninety-six per cent would be willing to talk to the ex-patient; ninety-one per cent would be willing to have him in the same social club with them; eighty-seven per cent would be willing to work with him; but only twenty-two per cent would be willing to have him marry someone in their family. When this final question of marriage came/

came up, more people mentioned "heredity" as a reason against it than had referred to hereditary factors in the earlier section on the causation of mental illness.

It seems that when the topic assumed more than casual interest and the respondent could suddenly imagine a real situation involving close contact, reactions could alter rather radically.

Zimbalist's second exercise in extracting information and attitudes towards mental illness from the inhabitants of St. Louis was a modification of the first study. The case sketches were revised and increased to five, by the inclusion of one "normal" and the division of the neurotic into a "withdrawn" and an "aggressive neurotic".

This time there was a striking difference in the percentage of respondents recognising mental illness. Ninety-four per cent recognised the new "aggressive psychotic", ninety per cent now recognised the "withdrawn psychotic"; seventy per cent recognised the "aggressive neurotic"; sixty-six per cent the "withdrawn neurotic" and twelve per cent considered that even the intended "normal" sketch was a picture of mental illness. In other respects the second survey tended to confirm the findings of its predecessor.

The case sketch method has since been employed in many surveys of attitude to the mentally ill but Zimbalist's findings do seem to case grave doubts on the value of this approach. Slight variations/

variations in the descriptions and in the number and context of these descriptions seem liable to produce widely varying responses. It is, however, noticeable that in both the St. Louis surveys there was a greater tendency for people to class aggressive rather than withdrawn behaviour as being indicative of mental disturbance.

One reason for dealing with Zimbalist's work in such detail is that is is perhaps less well known than some of those which will be discussed presently. It also provides a useful demonstration of the differences which can appear when only slightly modified questions are presented to a second sample of the same population. This salutary lesson should constantly be borne in mind when attempting to make comparisons between different surveys, carried out by different methods and widely separated in time and place.

Star and the Cummings

American and Canadian Conclusions

The nationwide survey planned and organised during 1950 by Shirley Star under the auspices of the National Opinion Research Centre of the University of Chicago, although never published, has nevertheless achieved wide renown. Shirley Star has spoken about the study on a number of occasions (1955, 1957) and has made the schedule which she used available to many interested research workers. Her general conclusions have, moreover, formed something of/

of a touchstone for subsequent speculation in this field.

This was most certainly an example of a large scale project, drawing upon the results of lengthy (1½ hour) interviews with 3,500 people, a representative sample of the entire American public.

Apparently without prior consultation, Star elected to employ the same method of short psychiatric case sketches which Zimbalist was currently using in Missouri. But she led into the topic gradually, asking first about what the respondent would regard as the most serious disease nowadays and going on to extract definitions of mental illness, insanity and nervous breakdown.

The impression emerged that most people were drawing a clear distinction between nervous breakdown and insanity, the former being curable, the latter not so. Mental illness seemed closer to the popular image of insanity, approximating to the psychiatric conception of severe psychosis.

In this schedule descriptions were then proferred of six cases and diminishing percentages of people saw them as mental illness,[8] as follows:

Paranoid - seventy-five per cent.

Simple Schizophrenic - thirty-four per cent.

Alcoholic/

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8 The respondents were asked whether anything was wrong and if so what; the possible cause of the condition and, finally, whether they thought the individual was mentally ill.

Alcoholic - twenty-nine per cent.

Anxiety Neurotic - eighteen per cent.

Childhood Conduct Disturbance - fourteen per cent.

Compulsive Phobia - seven per cent.

There were seventeen per cent who recognised none of these conditions as mental illness, twenty-eight per cent who limited this label to the violent paranoid and two per cent who regarded all the cases as mentally ill.

The public appeared to have very little personal familiarity with psychiatry; less than one quarter of the sample had any acquaintance with anyone who had been treated by a psychiatrist outside a hospital and they were mostly exceedingly vague regarding the function of the profession as a whole. At the same time people were not positively antagonistic towards psychiatry, they simply felt that it had, or was likely to have, very little relevance for their own lives.

The survey brought out differences in attitudes in relation to information and education. Respondents who had frequently been exposed to the subject of mental illness on the mass media had views which were closer to the professionals. The respondent's degree of education, concern with social problems, knowledge about mental illness and number of information sources were all correlated.

The/

The relatively small number of people who at that time did know of someone who was attending a clinic or visiting a psychiatrist privately were likely to report more information sources for the subject of mental illness.

Star proceeded to draw a number of general conclusions from such of her data as she presented. She had been struck, in the first place, by the widespread ignorance of a speciality which was already becoming very familiar to the upper economic and intellectual echelons of American society. At the same time as psychoanalysis was regarded as acceptable and almost necessary for the resolution of all manner of personal problems by the better off, it seemed to represent, for the majority of the population, a remote and inexplicable speciality.

Those people who were unfamiliar with the methods or the premises of modern psychiatry continued to associate mental illness more with custody than with care and to reserve the label in the main for behaviour which by its alarming violence, inappropriateness or sheer unpredictability aroused sudden protective reactions.

Star postulated a basic breach between the standpoint of psychiatry founded primarily, as far as America was concerned, upon psychoanalytic theory, and the beliefs of the general population. She suspected that the psychoanalytic point of view,/

view, with its concentration upon deeply hidden or unconscious springs of behaviour and its consequent implied disregard for personal responsibility, was fundamentally antagonistic to prevailing popular modes of thought. The equation which most people seemed to be making of mental illness and violent and irresponsible behaviour reflected general horror at the prospect of loss of "reason", the highest faculty of mankind.

People persisted in trying to find explanations for odd behaviour, even as it became more and more unusual, and so long as someone's actions could be rendered 'reasonable" or explicable in some sort of terms, the person in question was saved from the suggestion of insanity. Such explanations were necessary, Star suggested, because, for most ordinary social functioning, responsibility for actions has to be assumed.

But once a person had shown himself to be profoundly irrational and irresponsible and had been "put away" in consequence, no-one could ever feel quite safe or sure about him again (thirty-seven per cent of Americans thought that psychotics would always show some signs of their illness).

Star went further and enquired whether or not the attitudes towards psychosis which she had uncovered might not be indicative of an atavistic fear, a dread on the part of ordinary people that they themselves might suddenly lose their reason and which caused them to shrink from too close contemplation of the alarming subject of mental disorder.

Two/

Two of Shirley Star's most valuable contributions have been her demonstration of how far popular opinion can lag behind the views of specialists in this field and her illustration of the continuing importance of violence as an element in the concept of mental illness.

The idea of cultural lag is not a new one and can, of course, be applied to innumerable areas of interest besides mental illness. People's knowledge of most scientific and technical subjects is of necessity strictly limited and much of their behaviour must continue to depend upon premises and preconceptions which highly educated "experts" have left far behind. But this study does illuminate in particular the general ignorance of psychiatric concepts which prevailed in America in 1950, at a time when the subject was already in process of acquiring rather a fashionable reputation in certain restricted circles.

At the same time the relationship which Star noted between personal experience of the mentally ill and information on the subject has an encouraging aspect, suggesting that education in this area may not be so much formal as practical, attention being alerted to the subject once a person's interest is aroused.

Because some of the conclusions which were reached by the Cummings (1957) in their study of a Canadian prairie town were rather similar to those of Shirley Star, their work can conveniently be mentioned next.

The/

The study is described at length in their book, "Closed Ranks", where details of the two constituent surveys are laid out, including the interview schedule[9] and the scales.

This was primarily a controlled experiment in mental health education, with questionnaires administered to samples of the population before and after the propaganda. The educational programme was designed to stress the concept of a continuum in behaviour between the normal and abnormal, and depended upon the belief that peoples' behaviour could in fact be changed as a result of indoctrination. The Cummings wished to obliterate distinctions between health and illness in an effort to make people act towards the ill as towards the well. Implicit in all this was, however, the view of mental disorder as an illness but the suggestion was to be enforced that the mentally "ill" were only relatively different from the healthy.

The attempt was actually an exceedingly ambitious one aimed at nothing short of radically altering the belief systems of an entire community. (and a "conservative" one, at that) by processes of reasoned discussion and carefully phrased persuasion.

Although they were rather sceptical of the value of the mass media in changing attitudes, the Cummings decided they could not afford to ignore them and therefore employed radio programmes and news items in addition to their group discussions and lectures.

The/

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9 The Cummings used the same sketches of cases as Star had employed.

The optimism and conviction with which the Cummings approached their self-imposed task soon encountered some unexpected set-backs. The original welcome which the community had extended to this novel enterprise began to cool as its persistence and length gradually became apparent to the local inhabitants. Patterns of positive hostility had developed by the time of the resurvey and the interviewers had a very difficult time indeed when they tried to persuade people of the necessity for further co-operation in the project.

With intense seriousness, the Cummings categorised this disturbing situation in terms of responses which were:

"(a) Aggressive or hostile

(b) A removal or flight response

(c) Probably the response of apathy which might be a special case of flight."

They thought that the citizens had become "anxious and threatened", when asked to change their attitudes and that they had personally uncovered "a community pattern of denial and isolation of mental illness". They derived a definition of mental illness which they thought would accord with the prevailing views of the Prairie Town people: "Mental illness is a state of motivated unpredictability and non-normativeness for which a person is treated in a mental hospital". That is to say, they selected the same item of unpredictability which Star had noted as

a/

a constituent of the popular view of mental illness and they went further in suggesting that the term "mental illness" was closely bound up in the popular imagination with the picture of treatment in an institution.

The Cummings reluctantly concluded that people were simply not yet ready to accept the sophisticated notion of a continuum of mental states, they demanded a definite "cut off point" between the well and the dangerously insane. The latter should be "put away", out of sight and out of mind, leaving the rest to enjoy their minor eccentricities in peace.

But some of the incidental references in "Closed Ranks" are just as well worth noting as the broad conclusions of the authors. For example, they mentioned one respondent who had defaced a resurvey questionnaire by writing this across it,

"These questions are impossible to answer coherently. Answers would depend upon mental patients in question. I would fear an ex-patient who had committed murder or a serious sex-crime, but I would not fear one who had been docile or merely suffered hallucinations or other mild forms of insanity".

To which the Cummings responded,

" ..... This was an average citizen in terms of our categories and with his manifest lack of ability to discriminate between mild and serious forms of insanity and his tendency to associate mental illness with sex crimes and murder makes us count/

count him a failure from the point of view of our program".

It could just as well be argued, however, that this "average citizen" was expressing an eminently sensible point of view and one, moreover, which augured well for the maintenance of certain classes of ex-mental patients in the community. Far from showing "a manifest lack of ability to discriminate between mild and serious forms of insanity", the gentleman in question was in fact putting forward a very reasonably estimate of the limits of deviant behaviour which his community would be prepared, or advised, to tolerate. Incidentally, he was at the same time summarising fairly succinctly one of the major weaknesses inherent in all these community surveys, namely the difficulty of constructing simple schedule items which are unqualified and which therefore are liable to raise in the intelligent respondent's mind all sorts of reservations.

It is at least possible that some of the responses of this Canadian community were related as much to their intolerance of social psychologists as to their intolerance of the mentally ill.

Surveys after Star :
Some Surprising Results

A modest survey using some sections of Star's schedule was carried out by Rose (1957) on a sample of Minneapolis school pupils in their sophomore class (average age fifteen). The group totalled/

totalled 156 boys and 144 girls.

Rose found that girls had more knowledge and awareness of mental and nervous illnesses and were inclined to offer more "sophisticated" explanations of causation than boys. The girls stressed emotional causes, such as marital or parental troubles and not being loved as a child and were more prepared to treat a mentally ill person with sympathy and consideration. Asked about causes, more of the boys mentioned "too much brainwork" and "sex habits" and they were generally less subtle in outlook and less interested in the whole subject of mental illness.

Rose wondered whether an explanation for the differences might lie in the different "role expectations" for the two sexes. Girls, who had less possibilities for "role performance", were he thought, possibly forced to get to know peoples' emotions and motives as a way of influencing events.

Rose's study was a very small one and not properly representative of community attitudes but the work of Lemkau and Crocetti (1962), describing a survey in Baltimore in 1960, is of much greater interest because its results conflicted sharply with those obtained by Star and the Cummings.

Lemkau and Crocetti used three of Star's case sketches (the paranoid schizophrenic, the simple schixophrenic and the alcoholic) in constructing an opinion poll type of questionnaire schedule, which was then used by trained interviewers on a random sample of the/

the adult population (over eighteen years of age). The response was excellent, 90.2 per cent of all the chosen respondents participated (Total 1,736).

The authors were at pains to stress the care with which their sample had been chosen and the interviewers trained and checked since the unexpected results which they obtained might otherwise have cast doubt upon their methodology.

The respondents were in fact a group of poorly educated working class people, 40 per cent of whom were Negroes, and they proved to be already fairly familiar with hospitalised mental patients, 63 per cent having known two such persons. One per cent reported that they themselves had been in a mental hospital and 10 per cent had known of a close relative in this situation.

The surprising outcome of this survey was the recognition, by the majority of respondents, of all three persons in the Star stories as being mentally ill. For example, whereas 75 per cent of Star's sample had identified the paranoid, 91 per cent of the Baltimore sample did so; 34 per cent in the National Study identified the simple schizophrenic, against 78 per cent in Baltimore; only 29 per cent of the National sample had seen the alcoholic as a picture of mental illness but 62 per cent of Baltimore residents recognised him.

Fifty per cent of all respondents had identified all three cases/

cases as representing mental illness and only 4 per cent had identified none of them.

Lemkau and Crocetti looked for variables which were associated with the respondent's ability to identify these cases and they found that age, race, marital status and rural or urban birth were not significantly related to this capacity. But income and education level were directly correlated with the ability to recognise the subjects of the stories.

Next they grouped their respondents according to a two factor index of social status, based on education and occupation, which had been used by Hollingshead. Class V members in this system of categorisation were less likely to identify mental illness in all three groups than were the members of Classes I, II and III combined. Only 49 per cent of the lowest class achieved this as compared with 63 per cent of the higher classes. But what the Baltimore workers thought most remarkable was the fact that almost half of the lowest class had indeed managed to recognise mental illness in all the sketches. There was little suggestion here of "denial" of mental illness.

Furthermore, "enlightened" inhabitants of Baltimore did not regard mental illness as desperate and incurable and they failed to evince the tendency to "isolate and reject" a mental patient which had caused the Cummings such concern. For example, 85 per cent agreed with the statement, "people who have some kinds of mental/

mental illness can be taken care of at home", 62 per cent disagreed with the statement "almost all persons who have a mental illness are dangerous", and three fifths agreed with the statement that "people who have been in a state mental hospital are no more likely to commit crimes than people who have never been in a state mental hospital".

The respondents were also asked specifically whether they would advise home care for each of the central figures in three further case sketches. These described a withdrawn girl, a depressed male breadwinner and a mild senile psychotic. People recommended treatment at home for these patients in the following percentages, the girl, 56 per cent; the mild senile psychotic, 50 per cent; the depressed man, 46 per cent. There was little mention of violence as a reason for preferring hospitalisation and, when the topic was raised, it was found on enquiry to refer to the possibility of the elderly psychotic woman injuring herself as she wandered about in the night. Hospital was conceived of primarily as a place where care rather than custody could be ensured, and some people even postulated that it might do a patient positive good to get away from an unsatisfactory family setting.

As the authors of the report said, "The overwhelming majority of responses were patient or family orientated, humane in expression and rational in substance".

Reflecting/

Reflecting on these results, which had turned out to be so different from the findings of Star and the Cummings, Lemkau and Crocetti were inclined to postulate that a change in public opinion about the mentally ill might have taken place over the intervening decade. They were pleased to discover that some people were now beginning to look upon some mental illnesses as primarily illness, rather than deviant behaviour, since this might gradually result in more cases coming to competent medical attention. They ended by pointing out that if indeed such opinions and attitudes were susceptible to change this was not only an opportunity for "opinion leaders"[10] and educators but also a challenge to those people who, by deciding the form of the services and institutions for the mentally ill, could most effectively influence public views regarding them.

Lemkau and Crocetti did admit that it was possible that the Baltimore population was unusual in some respect, and there have been subsequent efforts to apply their survey to different populations. For example Mary Lemkau (1962), whose work was referred to in connection with doctors' attitudes (Chapter II, p. 50), used a questionnaire which was very similar to the one originally used by Lemkau and Crocetti.

It/

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10 The work of Dohrenwend et al. (1962) was mentioned in Chapter II (p. 45).

It was administered by sociology students to a sample of people in small communities in Carroll County, using town directories or tax maps as sampling frames. The total number of interview was 139.

The results showed up a very similar set of attitudes to those found by Lemkau and Crocetti in Baltimore. For example, 98 per cent of people in Carroll County had said "home treatment of a mental patient would be acceptable if the doctor thought it wouldn't do any harm". People in general proved to be thinking primarily of the patient's welfare.

As far as questions of social distance were concerned, the majority of the respondents could envisage themselves as coming closer to the mentally ill than in the previous studies, and the figures were very near to the Baltimore findings.

Meyer (1964) applied the Baltimore schedule to an urban, non-metropolitan area, the town of Easton in Maryland. The sampling method was stricter than in Mary Lemkau's survey, since a useful frame was available in the files of the local electricity board relating to every meter in town. Every nineteenth meter was drawn, to give 116 dwelling units. Thereupon the household members were enumerated and an adult respondent drawn at random.

The entire Baltimore questionnaire was then administered to the sample and one hundred interviews were completed (86.1 per cent of the total sample).

Meyer/

Meyer found that the Baltimore findings were replicated in Easton, the percentages of people identifying the three case sketches as mental illness being very close indeed.

In the hypothetical questions posed to estimate social distance, results were again fully comparable with Lemkau and Crocetti's findings and partly similar to the Carrol County ones. There was admittedly a gradation of permitted contact from a maximum in impersonal situations to a minimum in close intimate relationships, but as many as 44 per cent of people said: "I can imaging myself falling in love with a person who had been mentally ill".

Meyer considered that the results indicated that most Easton people were not denying the presence of mental illness or rejecting the mentally ill. He thought that this population were either showing a greater awareness of the signs and symptoms of mental illness than did the Cummings and Star samples, or else that they were less inclined to "deny" the disorders.

So there have now been three similar type surveys within the State of Maryland, all tending to suggest that the population sampled were both reasonably humane in their attitudes to mental illness and aware of a number of differing manifestations of mental disorder.

LATER/

LATER LARGE SCALE SURVEYS: NEW AIMS AND METHODS

The approach of another nation wide survey into conceptions of mental health by Gurin, Veroff and Feld (1960) was very cautious and particular care was taken neither to arouse antagonisms when raising delicate topics nor to suggest the desired replies. The result, "Americans View their Mental Health" is a very large, 450 page volume impossible to summarise in a review of this kind.

But the researchers had some observations to offer on the evidence that members of the lower social classes apparently did not "feel the need" for expert help in the resolution of their "problems": since such help was in most instances unknown or unavailable to most potential lower class patients this lack of demand was perhaps understandable in the circumstances.

This study employed the widest possible definitions of psychiatric competence and tended to elevate virtually all "personal problems" to the status of minor illness. In fact it appeared that only a minority of those questioned had actually gone for help to a psychiatric facility preferring, in most instances, the more familiar reassurances and advice available from their family doctor, priest or pastor.

Another very extensive study now reported in book form under the/

the title of, "Popular Conceptions of Mental Health" has been the work of Jim Nunnally and his associates from the Institute of Communications Research at the University of Illinois (1961)[11]. This was in progress during the period 1954 - 1959 and employed specially designed instruments and careful sampling of various different groups.

The measuring instrument was developed from an initial collection of over 3,000 statements on mental health topics which were gradually sifted and condensed, in a series of stages, into a final list of 50 items. Pre-testing of these items and the application of cluster analysis to the results revealed ten separate groups of items which were termed "information factors"[12].

Nunnally's/

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11 The portion of Nunnally's work referring to the mass media was mentioned in Chapter II (p. 42).

12 Nunnally's factors were grouped about these statements:

(1) The mentally ill look and act differently from normal people.

(2) Willpower is the basis of personal adjustment.

(3) Women are more prone to mental disorders than men.

(4) Avoiding morbid thoughts will promote mental health.

(5) Mental health can be maintained by guidance and support from strong persons in the environment.

(6) Mental illness is hopeless.

(7) Mental disorders are caused by immediate environmental pressures.

(8) Emotional difficulties are not serious.

(9) The old are more susceptible to mental illness.

(10) Organic factors such as poor diet and disease cause mental illness.

Nunnally's was an entirely different approach from that of Star and her successors. The case sketches were abandoned and in their place were put more conventional attitudes and opinion measures.

In addition to the measures of information, special instruments were devised to study attitudes, relying mainly upon the Semantic Differential scale of Osgood, Suci and Tannenbaum (1957). Free association tests and pair comparison techniques were also employed with, in addition, ranking methods and rating scales.

The sampling method employed relatively small groups, from 100 to 700 persons, deliberately constructed so as to be representative of the country as a whole in terms of certain demographic characteristics. The team also made upe of an "opinion panel", specially organised for the purpose, drawn from central Illinois. This panel also was an approximate minature of the United States population in regard to sex, age, education, income and religious affiliation. Nunnally justified the use of these groups and panels by the fact that he was in search of central tendencies, correlations and relative responses, rather than absolutely precise results.

The Illinois respondents proved to have an ill assorted set of opinions regarding mental illness. Those over 50 years of age and those who had not gone to high school were less well informed than the younger and better educated respondents.

The/

The attitude measurements produced less encouraging results than the Maryland research had obtained, local reactions being closer to the negative and distrustful feelings uncovered by Star and the Cummings. The mentally ill were generally regarded as untrustworthy and unpredictable, psychotics being disliked more than neurotics. The latter were conceived of as weak, often female, but intelligent, whereas the word "psychotic" tended to call to mind the old and the ignorant.

Attitudes, in contrast to information, seemed to be only slightly related either to age or education. Nunnally and his group considered that opinions were presently in a state of flux and were probably susceptible to influence by experts. But attitudes seemed still to be centred around the fundamental unpredictability and possible violence of the mentally ill. The topic caused anxieties which were not easily allayed by the vague pronouncements of most mental hygienists.

Nunnally suggested that the situation could possibly be improved if the language used for conveying information about mental illness could be made more clear, interesting and authoritative or, at least, couched in terms which the public could understand[13]. It would be of no use simply to destroy peoples'/

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13 This recalls the finding of Freeman and Kassebaum (1960) that a knowledge of the technical language of psychiatry was related to higher education, and Star's postulate of a small educated "sub culture" which was at home with psycho-analytic concepts.

peoples' current information without replacing it with something definite and at the same time reassuring[14].

One of the remaining really large American surveys was of the cross-cultural variety and has already been mentioned (Chapter II). It was carried out by Askenasy and Zavalloni (1963) for the World Federation of Mental Health and the results were published for private circulation in two large volumes.

The research directors postulated that some of the contradictory results previously obtained in assessing attitudes to mental illness might simply reflect differences in the dimensions being tapped by different researchers. Since attitudes had many aspects or dimensions they considered that it was not surprising if people expressed inconsistent or negative sentiments, particularly when the subject under debate was itself very complex. They intended therefore to investigate existing felt distinctions between nervous breakdowns and mental illness.

They were also interested in drawing a distinction between attitudes to the mentally ill person conceived as a deviant, and therefore almost be definition rejected by society, or conceived as a sick person, who might be expected to excite help and/

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14. In the course of the Cummings' re-survey, after the propaganda drive, one of the respondents remarked that he did not know that masturbation could cause mental illness until he had heard the psychiatrist talk about it. It turned out that the psychiatrist had been trying to say that the practice could cause anxiety, and that anxiety could lead to mental illness. This seems to be an example of what mental health education should <u>not</u> do.

and sympathy. The medical viewpoint had, they believed, distinct advantages over the somewhat determinist sociological perspective, and its wider acceptance would be welcome.

As has been mentioned earlier (Ch. II, p. 50) they were mainly concerned with the practical difficulties facing the ex-mental patient in search of employment, so their samples were drawn from potential employers and co-workers in the psychiatric field on the other.

In general the results showed that people in Oxford, Hawaii and the U.S.A. were indeed drawing a distinction between mental illness and nervous breakdown. The English respondents, moreover, seemed the most tolerant of all towards the mentally ill.

Askenasy and Zavalloni did not favour the invention of a new terminology to convey information about mental illness. They recommended a more widespread use of the available term, "nervous breakdown", with its comforting connotations of mild and curable disability.

Perkins, Padilla and Elinson (1965) have recently commented upon, "Public Images of Psychiatry" as the result of a survey carried out among a random sample of New York's adult population.

A structured questionnaire was employed, relating to attitudes towards various types of community mental health services; opinions and knowledge about psychiatry; attitudes towards ex-mental hospital patients; concepts of mental disorders; path-

ways/

pathways to care, and personal experience or contact with mental health services.

The sample was a multistage, stratified one drawn from 1,500 households and consisting of adults over twenty. The total who answered the questionnaire was 710. Economy of sample size was achieved by employing three overlapping questionnaires, each one being directed at a random third of the main sample.

The respondents were sorted according to educational and occupational groupings and personal experience. A majority knew one or more people who had received professional help for some mental problem.

Regarding social relations with ex-mental patients, only 23 per cent would share an apartment with such an individual and only 24 per cent would be willing to have a member of their family marry someone in this category. But 76 per cent would be prepared to have an ex-mental patient as a co-worker; 73 per cent as a neighbour; 66 per cent as an employee and 55 per cent as an employer.

The public were generally dissatisfied with the current provision of mental health services and there was a demand for such extras as a telephone answering service for emergencies; walk-in, or what were picturesquely termed "trouble shooting" clinics; psychiatric services in general hospitals and better after/

after care facilities. But people were generally averse to the idea of open mental hospitals, night hospitals, day hospitals or foster care.

Almost half the sample were unaware that a psychiatrist was a medical doctor.

Most people expressed the belief that the State Mental Hospitals, "protected the community", and some compared their function with former sanatoria. Even if the patient did not get better he was at least out of harm's way and unable to do harm.

The authors summarised the situation in these words, "With some exceptions, such as neighbourhood after care ..... in general greater acceptance was placed on 'threat reducing services', which permit quick handling of psychiatric problems, and less acceptance was placed on, 'threat inducing services', which bring patients in closer contact with members of the community".

This then seemed to be yet another piece of evidence of the part still played by fear and anxiety in relation to the mentally ill.

The debate between those who have discovered these negative emotions and the others who have revealed broadly humane and tolerant attitudes has never yet been satisfactorily resolved. Possibly, as Askenasy has suggested, the search for consistency is/

is in vain. It is by no means impossible that people should feel different emotions towards the same object. It is not at all unreasonable for people who are visualising a mentally ill person as someone with mild peculiarities or a tendency to excessive worry, to regard such a person with equanimity or mild concern. But, if they are conjuring up a picture of someone who is liable at any moment to become violent and "berserk", they do well to express their apprehension. Violence is certainly alarming and society is at all times organised to minimise it.[15]

It is certainly significant that the use of the same measuring instrument seems to have been producing similar results, whereas a different schedule was attended by contradictory replies. The context of questions has for long been recognised by experimental psychologists as an important variable, modifying the results obtained. The example of Zimbalist's two successive surveys is very striking, an alteration in the number of case sketches produced different results from a second sample of the same population.

It is unfortunate that controlled experiments could not have been carried out using, for example, Star's schedule in Maryland and Lemkau and Crocetti's questionnaire in, "Prairie Town"./

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15 Though it is probably the case that the amount of violence which is acceptable is related to social class. For example, beatings may sometimes be suffered as part of their lot by working class wives, whereas even quite moderate verbal "aggression" can be sufficient to constitute mental cruelty in suburbia.

Town". But far too much water has already passed under the respective bridges for any such expensive plans to be even remotely practicable. Meanwhile attitudes and opinions are changing as information and experience accumulates.

FOCUS ON SELF-RELIANCE - A FRESH VARIABLE

More recently, Phillips (1963; 1964) has bypassed the main debate and focussed his attention upon a tangential aspect of this complicated subject.

He observed that most previous studies had either taken a person's behaviour as the factor determining rejection by others, or else that they had focussed on the significance of a person's becoming labelled, and subsequently rejected, on account of his receiving mental treatment. Phillips thought that the other help sources[16] which people approached could influence public attitudes towards individuals whose behaviour was disturbed.

Phillips therefore planned to introduce into the picture of disturbed behaviour an additional element, help-seeking from one or another source, in order to discover whether public reactions did in fact vary in relation to this piece of information. Phillips considered that the current American ethos laid great stress upon self-reliance and that people who gave/

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16 As enumerated in Gurin, Veroff and Feld's study, (see p. 104 above).

gave evidence of not being able to manage their own "problems" without help would tend to be disapproved. He thought that it was not simply psychiatric aid-seeking which might cause someone to be discredited but that looking for any kind of help would be regarded as evidence of weakness.

His sampling method was ingenious. He drew 300 households from the telephone directory of the New England town of Branform. From the households he selected white, married women. Then by dividing the main group into five smaller ones of sixty individuals each and by applying five variations of the main questionnaire he had the elements of a Graeco-Latin square design, which permitted him to derive the maximum possible amount of information from a relatively small sample.

The schedule utilised four case abstracts based on Star's sketches of a paranoid schyzophrenic, a simple schizophrenic, an anxious-depression, and a phobic compulsive individual. In addition a "normal" man was described. The five case abstracts were accompanied by information about help-sources, ranging from none through a clergyman, a physician and a psychiatrist to a stay in a mental hospital.

Respondents were also asked to indicate how they would place such a person on a social distance scale varying, in this case, from marriage to neighbourly relations.

It appeared that even the supposedly normal individual was rejected/

rejected by most people when he was described as seeking help, particularly if he was having psychiatric or mental hospital "treatment".

Apart from the paranoid schizophrenic, the people who were behaving unusually were more and more liable to rejection in relation to the type of help which was sought, attendance at a mental hospital being at the worst end of the scale. But the violent, paranoid schizophrenic was expected to seek some kind of help and was rejected for neglecting to do so.

People with relatives who had had a nervous breakdown reacted differently to the suggestion of help-seeking by rejecting individuals who had failed to seek help.

Personal adherence to "the norm of self reliance" was associated with respondents' increased rejection of people who were reduced to getting help with their problems.

Phillip's work ties up closely with the studies on sickness behaviour to which reference has already been made (Chapter I). Indeed, he pursued this aspect in another paper (1965) where he described an investigation which showed that subjects (again a group of married, white women) who placed the strongest emphasis on self-reliance were those least likely to adopt the sick role themselves. The situations which he postulated for them were, insomnia; lack of concentration and talking to oneself; worry and depression of several days duration and, finally/

finally, a temperature of 101°.

In still another experiment (1964) Phillips replicated his first study but this time indicated the sex of the help seeker. Men who sought help were more rejected than women with the same symptoms and sources of help. Allowing for the fact that all Phillip's respondents have been women, it does nevertheless appear as though men are expected to be able to cope with their difficulties unaided and will lose face more easily than women if they are obliged to admit to someone else that anything is wrong.

A somewhat similar line of thought has been developed by Jourard (1964) in, 'The Transparent Self'. Jourard has developed a Self-Disclosure Questionnaire which he has applied to men and women, showing that women are inclined to disclose more about themselves than men.[17]

However, Jourard also reported on some unpublished data which showed that students who went for help to the campus psychological counselling centre were lower disclosers than matched groups of students who had not sought such clinical services, although some of the applicants for counselling had obtained unusually high disclosure scores. The results are rather contradictory and scarcely what would be expected from Phillip's work on help-seeking. Jourard says: "excessive disclosure/

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17 But this result has not been replicated by all investigators who have used the questionnaire.

disclosure may be as incompatible with optimum adjustment in the college milieu as unduly low disclosure". But he was not concerned directly with the view which others take of high self disclosure.

All Phillip's studies, like so many others, revealed a relationship between age and education and attitudes. Women under thirty-five years of age who had received a college education were the most tolerant and capable of "recognising" behavioural abnormalities as mental illness.

Phillip's work has gone some way towards closing the gap which has seemed to persist between peoples' reaction to physical and mental illness. Parsons assumed that in the case of physical illness a patient was applauded for seeking competent help from a specialist source at an early stage of the disease. Phillips is suggesting, however, that by some people this action may be regarded as a sign of weakness. People who are themselves disinclined to seek advice for the relief of minor symptoms will be liable to condemn such evidence of inadequacy in others.

As far as mental illness is concerned, the conception of abnormal emotions or behaviour as illness still does not seem to have gained general acceptance. People are judged by others in terms of their overt behaviour. Feelings may only be disclosed to the most intimate acquaintances or to psychiatrists whose advice may be sought.

It/

It seems as though violent, disruptive and obscene behaviour will not be tolerated in any circumstances, but that a great deal of personal anxiety or minor oddities of behaviour may escape notice until someone marks themselves out as being in difficulty by going for help. The process of seeking help for what other people may regard as minor, commonplace, problems may put the help-seeker at a relative disadvantage in the eyes of sturdily self-reliant characters. If the help which is sought is psychiatric there is a further element of stigma involved, for popular stereotypes still associate psychiatrists and mental hospitals with the treatment of bizarre and violent behaviour.[18] The observer then condemns the help seeker as not merely inadequate but positively irresponsible and liable thereafter to act oddly or dangerously or both.

RECENT BRITISH STUDIES

The great majority of studies[19] of public attitudes to mental illness and the mentally ill have come from America where conditions/

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18 In his article, "Social Support for Stereotypes of Mental Disorder" (Scheff, 1963) has drawn attention to the support given in the mass media and in ordinary conversation to the relationship between mental illness and violence. Newspapers are continually reporting on the violent acts of patients and ex-patients, ignoring the great mass of quiet and peacable members. As Scheff says, "The vivid portrayal of a single case of human violence has more emotional impact on the reader than the statistics which indicate the true actuarial risks from mental patients as a class". He makes the same points at greater length in his book, 'Being Mentally Ill: a sociological theory' (1967).

19 Halpert (1963) has produced a useful summary of the major American surveys in this field.

conditions are, in many respects, different from Britain. The organisation of the medical and mental health services, the paths to the mental hospital, committal procedures, the field of operations of the private psychoanalyst are all different. The populations at risk also differ greatly, from the comparatively homogeneous British society to the complex of races, cultures and creeds which go to make up America. Whilst it is always dangerous to talk about national characteristics, it does seem possible that the British, after twenty years of "socialised medicine", may be less inhibited about help-seeking, less concerned on the whole about a "norm of self-reliance".

Such investigations as have so far been made have tended to bear out the hypothesis that the British are more tolerant and are more inclined to view mental illness as an illness. Askenasy 's survey among Oxford workers and employers has twice been mentioned but probably the best known British study was carried out by Belson (1957) in connection with a series of B.B.C. television programmes on "The Hurt Mind".

Eight hundred people, whose decision to view or not to view had been made without knowing that an enquiry was to take place, were invited in small groups[20] to the studio to give their views on mental illness and the mentally ill. The series had the effect of increasing peoples' knowledge on the subject and their confidence in medical doctors' ability to cure mental illness/

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20 Belson (1960, 1963) has described in other papers his use of carefully controlled groups of people for audience research and other kinds of market research.

illness, as an illness, and it also increased their sympathy for the mentally ill and their readiness to associate with ex-mental patients.

But, apart altogether from changes in attitudes, viewers were found at the outset to have a certain set of opinions. For example, about three quarters drew a distinction between mental illness and insanity, regarding the latter as more or less incurable. They were able to produce groups of symptoms which, to their minds, characterised the mentally ill. These ranged widely from symptoms of anxiety, through paranoia and depression to alcoholism and psychopathy. About half the viewers specified that the mentally ill differed from normal people in respect of certain aspects of social behaviour, such as being "irresponsible", "dirty" or "a danger to others". About a tenth referred to "fear and withdrawal" on the part of the mentally ill.

The great majority of people expressed positive sympathy towards the mentally ill and declared that they were "sorry for them" or "would like to help them".

The causes of mental illness were seen as mainly environmental, like housing and family difficulties. About a quarter mentioned heredity. There was considerable confidence in the prospects of cure, about three quarters thought that nowadays a cure was effected "very often". But everyone thought that the cure prospects of fifty or more years ago had been very poor, the majority said that it had occurred "hardly ever", or "not at all".

When/

When people were asked about treatment methods now and formerly they contrasted their current conceptions of rest, psychoanalysis and "kindness", with previous regimes of "isolation, punishment and discipline", in "insanitary, grim, gloomy buildings", which "functioned as dumping grounds and not as hospitals".

Over half the people in the groups personally knew someone who was mentally ill and about three-quarters said that they had known someone like this at some time. About forty per cent recalled seeing a film dealing with the subject of mental illness.

This London survey of ten years ago provided a picture of current opinions and attitudes which was closer to Lemkau and Crocetti's findings than to the discouraging evidence of Star and some others. It showed people who were conscious of changes in the treatment of the mentally ill and who were in agreement with the direction which the reforms had taken. The majority of the respondents declared their own personal acquaintance with mentally ill people and were sympathetic towards them. But, at the same time, remnants of the old stereotypes remained, in the association of the mentally ill with dangerous and irresponsible behaviour and in continuing adherence to a concept of "insanity" as a separate condition, dreaded and fundamentally incurable.

In an entirely different environment, the Vale of Glamorgan, South/

South Wales, Rawnsley and Loudon (1967)[21] have lately been engaged upon a two-pronged investigation, aimed at estimating the incidence of certain psychiatric symptoms together with the prevailing attitudes towards these symptoms.

Various measures of psychiatric morbidity were used, among them 100 selected questions from the Cornell Medical Index. The 720 respondents[22] were shown the questions typed on separate cards, and were then asked certain standard questions regarding those cards to which they had given an affirmative response. This mode of presentation was specially devised to lessen the influence of the interviewer upon the respondent and to maintain uniformity in the interviews (Ingham, 1965). At the same time the relationship between the participants in the encounter could still be maintained.

The supplementary questions which were asked related, firstly, to the severity of the symptoms and whether advice had been sought regarding them. The interviewer then went on to discover how the respondent would react to similar symptoms in a friend.

The underlying hypothesis was that people most inclined to seek their doctor's advice for certain symptoms would also be most sympathetic to these complaints in others.

In the paper previously mentioned in Chapter II, Rawnsley (1966)/

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21 Personal communication.

22 A stratified random sample of people aged 26-45 was drawn from a total population of approximately 14,000.

(1966) has reported upon some of the epidemiological aspects of the survey. The attitudinal section, however, has not, at the time of writing, been published. The results will be awaited with particular interest as they are exploring the same area of relationships between help-seeking and attitudes which have recently engaged the attention of Phillips, Jourard, Mechanic and Volkart.

Rawnsley's study of student attitudes (Chapter II, p. 56) was also concerned in a sense with assessments of what Phillips would term, "self-reliance". Presented with a variety of descriptions of behaviour (several of them normal) the students were asked to indicate whether they considered anything to be amiss and, if so, whether the individual should cope unaided. If aid was advised, the respondent had then to indicate what type of help he would recommend.

Medical students' interest in psychiatric complaints as compared with physical complaints were measured in conjunction with the preceding section of the questionnaire. The enquiry did not, however, contain any estimate of the respondent's own "sickness behaviour", or reaction to personal "problems".

Another community study has been in progress in Manchester under the direction of the sociologist, Rose[23]. This involved measuring peoples' reactions to the mentally subnormal as well as to ex-mental hospital patients. People were also asked about their/

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23 Personal communication, 1965.

their knowledge of the treatment facilities available for both these groups. Leading on from this were questions regarding the establishment of a hypothetical hostel for discharged mental patients and whether and why the respondent would object.

Personal experience of the mentally ill and the mentally subnormal was taken into account as well as exposure to the subject of mental disorder on the mass media. Educational level and social class were noted, presumably in the expectation that these variables as well as experience might be related to attitudes towards and information regarding mental illness and subnormality.

The results of this last enquiry are not yet available. When they do appear it should then be possible to compare, at least in some respects, the attitudes towards ex-mental patients of people in London (Belson), Oxford (Askenasy), Manchester and Glamorgan.

CHAPTER V

AIMS AND METHODS OF THE EDINBURGH SURVEY: PREPARATION OF THE MEASURING INSTRUMENT

The study in Edinburgh which will now be described was first envisaged in October, 1964. A review of the British and American literature (as summarised in the preceding four chapters) had already begun to indicate the wide variety of investigations which had taken place, from many different points of view, into the level of public information in the field of mental illness and into prevailing attitudes towards the mentally ill. But the relative paucity of systematic studies in samples of the general population in Britain, together with the complete absence of any such studies in Scotland, seemed to encourage an attempt to evaluate the state of existing opinion among the citizens of Edinburgh.

Stage 1 - Talks with interested professionals

The first stage in the investigation consisted in arranging for meetings with two groups of people, firstly, with psychiatrists and sociologists whose particular interests lay in this branch of social psychiatry and, secondly, with a number of mental health personnel and social workers currently engaged in the rehabilitation of the mentally ill in Edinburgh itself.

In/

In the course of visits to Aberdeen, Cardiff and Dingleton (Melrose) an impression was formed of work proposed or in progress in this field and some of the main problems of methodology were usefully discussed.

On the occasion of a refresher course arranged in Edinburgh for a group of Mental Health Officers an opportunity was afforded to observe the viewpoint of these officials on the topic of local community attitudes. Their own outlook seemed superficially to be somewhat authoritarian.

Exploratory interviews were also undertaken with officials involved in the resettlement of ex-mental patients in the City. These included the Disablement Resettlement Officers, the Industrial Rehabilitation Officer in the Government Unit at Granton and the warden of a men's hostel. It was interesting to note the very narrow range of attention of people primarily concerned with the practical day to day problems of resettlement and management.

Stage 2/

Stage 2 - Formulation of the Aims of the Edinburgh Study

By this time the broad aims of the forthcoming study had been established. The intention was to investigate, in a sample of the Edinburgh population, the current attitudes to mental illness and mental patients and some of the prevailing opinions regarding the causes, course and prospects of cure of mental illness. The aim of the proposed study would not only be to elicit these opinions and attitudes in a sample of the population but also to examine their distribution in several social and demographic sub-groups in order to discover whether any significant differences existed between the information and attitudes held by these separate sections of the community. Many of the American studies, for example, had demonstrated differences in relation to age, experience and education. It would be of interest to see whether the same factors were operative here.

It was appreciated that the terms "mental illness", "the mentally ill" and "ex-mental patient" might hold different connotations for lay people and psychiatrists. It appeared that psychiatrists were accustomed to use the term, "mental illness" as a comprehensive expression, embracing a wide range of psychiatric disorders; lay persons, on the other hand, were probably inclined to use in addition other words or phrases, such as "nervous breakdown" or "insanity" which marked either extreme of a popular continuum of psychiatric dysfunction/

dysfunction but which no longer formed any part of the vocabulary of the specialist. It was hypothesised that the popular mind might sometimes see in the term "mental illness" a more serious label than "nervous breakdown", but a less serious label than "insanity". However, if the actual topic of the investigation was even to be mentioned[3], it would be necessary, within the confines of a structured interview, to employ the same phraseology or form of language throughout. This set of terms was therefore chosen, with full realisation of its limitations, but in the hope of introducing internal checks as an aid to discovering the import of the terms for individual respondents.

It will also have been noted that the aims of the study included reference to both opinions and attitudes. The definitions of attitudes and opinions have engaged the attention and exercised the ingenuity of psychologists and sociologists for nearly fifty years. A recent useful summary of the concept of attitude is to be found in the first section of the book, "Attitudes: selected readings", edited by Marie Jahoda and N. Warren (1966). Probably the most generally accepted definition is Allports' (1935), "An attitude is a mental and neural state of readiness, organised through experience/

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3 Instead of being treated obliquely as, for example, in the work of Rawnsley and Loudon.

experience, exerting a directive or dynamic influence upon the individual's response to all objects and situations with which it is related".

The purpose of the Edinburgh enquiry, however, was not merely to elicit attitudes, more particularly since it could not be decided beforehand whether attitudes towards mental illness and the mentally ill were well defined and coherent, but also to explore simultaneously the existing level of public knowledge about these matters.

As Sprott (1952) has said, "The distinction between what we mean by 'attitude' and what we mean by 'opinion' cannot be closely pressed, but the more emotionally charged, the more people mind about a matter, the more we would use the word 'attitude', the less they mind, the more they are 'purely' intellectual, the more we would use the word 'opinion'". Although this definition might be insufficiently precise to satisfy some psychologists, it nevertheless expressed the difference which has in fact been implicit in the Edinburgh study between attitudes and opinions, the former relating primarily to peoples' feelings towards the mentally ill and ex-mental patients, the latter relating to information or beliefs regarding the development of mental illness, its treatment and its outcome.

With these considerations in mind, it will now be possible to/

to consider the gradual development and refinement of the measuring instrument employed in the Edinburgh study of attitudes and opinions in relation to mental illness and the mentally ill.

Stage 3 - Preparation and testing of the first draft questionnaire

The information obtained from the literature together with the suggestions gained from consultation with various interested individuals was now beginning to take shape in the earliest draft questionnaire.

This preliminary schedule (which is reproduced and summarised in the Appendix, p. 234) dealt in turn with the following areas of interest: demographic data on respondents, covering age, sex, occupation, religion, education and income; data relating to the respondent's personal experience of mentally ill persons, of mental hospitals and of people who, whilst not defined as mentally ill, had evinced odd or anti-social behaviour; other sources of knowledge and information about mental illness, such as the press, television and literature; a set of ninety attitude and opinion statements, culled from a variety of sources[4] and to which the respondent was required to indicate their degree of agreement or disagreement/

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4 Such as Nunnally's work (see p. 105 above), Belson's B.B.C. inquiry, other surveys and the popular press.

disagreement[5]; a set of statements devised to detect the degree of social distance which would intervene between the respondent and a hypothetical ex-mental hospital patient[6]; further statements to elicit the amount of sympathy or intolerance felt towards a series of specified persons, ranging from a woman who had suffered a nervous breakdown to a man who had spent a year in a mental hospital[7]; a statement of the respondent's estimate of their own tolerance for the mentally ill as compared with their estimate of other peoples' tolerance[8]; questions relating to possible stigma attached to the mental illness of a close family member; questions on any perceived alteration in public attitudes to mental illness and mental patients over the past twenty years or so; a modification of the Gough-Sanford rigidity scale[9]; finally, the respondent's own recipe for avoiding mental and nervous troubles.

To/

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5 After the form of a Likert type of scale (1932).

6 A modification of the Bogardus (1925) social distance scale.

7 Following Phillip's suggestion that tolerance varied with sex and source of help seeking (see p. 113 above).

8 After Foulds' (1958) Superiority - Inferiority index.

9 Gough, H.G. and Sanford, R.N. (1960). This aspect of personality was thought to be possibly relevant to tolerance for the mentally ill.

To summarise, this preliminary questionnaire was aiming to set the graded answers to a large number of opinion and attitude statements against a group of demographic, social and personality variables.

In its original form this draft questionnaire was pre-tested on a first pilot group of ten individuals, chosen very roughly to range in age and social status and with equal numbers of people of either sex. At this stage only its basic applicability and its duration were being assessed. It was found, for example, that the mode of presentation of the attitude and opinion statements, which involved the sorting of cards bearing the specific statements into boxes according to the extent of agreement or disagreement with their content, was well tolerated by this small group of respondents. But sections of the schedule seemed tedious and repetitive and it was, on the whole, much too long.

Consultation with colleagues in the M.R.C. Unit in the Department of Psychiatry followed and their assistance was sought in refining and rationalising sections of the original instrument. For example, the ninety statements of attitudes and opinion of mental illness and the mentally ill were circulated to the ten members of the Unit so that informed criticism of the items could aid in eliminating those which were confusing, repetitive or valueless.

The/

The result was to reduce considerably the original list of opinion and attitude statement, and the remainder were then sorted into four groups. These were, respectively, attitudes towards the mentally ill, and opinions regarding the causes, course and prospects of cure of mental illness.

Members of the Unit also assisted in grading the social distance items in Section V, Item 49 of the draft schedule.

Other modifications of the proposed demographic data were put forward. Income, for example, was thought to be dispensable as an item of information and also possibly liable to provoke resistance on the part of respondents. It was advised that questions of religious observance should, in a town like Edinburgh, be approached with especial care.

Stage 4 - Standardisation of Opinion Items

As explained above, the remaining opinion statements had been sorted into those concerned with the causes, course and prospects of cure of mental illness. In order to standardise these statements, in the sense of obtaining a measure of specialist opinion, it was decided to seek the co-operation of a group of consultant psychiatrists. Accordingly the consultant psychiatrists in the professorial teaching units of each Scottish University Medical School[10] were approached and asked/

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10 Glasgow, Edinburgh, St. Andrews (Dundee) and Aberdeen.

asked to fill in the extract from the evolving questionnaire which is reproduced in Appendix II[11] (p. 256). Twelve out of a possible thirteen consented to the exercise and completed the brief questionnaire. Several psychiatrists provided valuable additional comments and criticisms relating to the form and content of some of the statements as they were then phrased, suggestions which were to prove useful in the ultimate modification of the schedule for use on the general population.

When twelve completed forms had been received from the consultants they were then put aside for subsequent consideration along with the results from the second pilot study.

Stage 5 - The construction of the second draft questionnaire and the conduct of the second pilot survey

As a result of discussion with colleagues and with advice from other sources the original instrument had by this time been considerably modified both in length, in form and in content (see Appendix III).

The demographic data had been relegated to the end of the schedule where it was considered to be less likely to cause resentment on the part of a respondent faced suddenly with an inquisitive stranger. The first question was a new one, requiring the respondent to rank in order of severity ten diagnostic/

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11 The letter accompanying the relevant section of the questionnaire is also reproduced in the Appendix.

diagnostic terms. Seven of these referred to physical illnesses, but there were three terms for psychiatric disability, namely insanity, mental illness and nervous breakdown. The object was to use respondents' ranking of these three terms as some indication of the meaning which 'mental illness' held for them, since this was to be the recurring theme of the remainder of the questionnaire. At the same time, answers to this question would be indicative of the relative concern with which respondents viewed psychiatric disturbances as compared with, say, cancer.

The effort to seek for descriptions of eccentric or deviant behaviour short of acknowledged mental illness had now been abandoned since it seemed too complex and time-consuming, and attention was confined to the respondent's experience of persons already labelled as mentally ill.

Whereas the central section of the questionnaire had previously consisted of ninety opinion and attitude statements, it had now been pruned to fifty-two and many in this remaining group had been altered in their wording.

The presentation of the group of questions relating to a respondent's possible reaction towards several specified mental patients had been changed and the order of the supplementary questions had been varied to reduce monotony.

The final sections of the schedule had been greatly abbreviated/

abbreviated[12] and now dealt shortly with knowledge about certification, the respondent's views on self reliance[13] (Question 71) and on possible local changes in tolerance for the mentally ill. There still remained the ultimate opportunity for a respondent to sum up in their own words their "recipe" for avoiding mental illness.

Once it had been redesigned, the questionnaire was ready for use in the second pilot study. This was a much more deliberate affair than the first pilot, using as subjects a group of twenty-four women, aged 35 - 55[14], of varying educational and social class with varying experience of mental illness. The women fell into four groups of six:

(a) Women with primary education only and with close experience of mental patients. These were a group of domestic aides employed in the psychiatric wards of Mackinnon House and the Andrew Duncan Clinic, Edinburgh.

(b) Women with primary education only and with no specific acquaintance with the mentally ill in the course of their work. They were domestic workers in the general medical and surgical wards of the Royal Infirmary, Edinburgh.

(c) Women with secondary education (and belonging to Social Class I or II) who had personal experience of mental illness in a close relative. These women were the relatives of male psychiatric patients occupying private beds.

(d) /

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12 For example, the Gough-Sanford rigidity scale, whose relevance to the inquiry was by now called in doubt, had been discarded.

13 After Phillips (see p. 113 above).

14 Thus age and sex were held constant.

(d) Women of similar education and social class as (c) but without close experience of mental, as opposed to physical illness. They came from the Womens' Voluntary Service and worked with general medical and surgical patients.

The purpose of choosing these contrasting sets of people to answer the questions was, firstly, in order to discover whether in fact there seemed to be a difference in responses according to class (which is closely bound up with education) and personal experience and, if this was the case, to indicate which of the questions differentiated best between the separate types of respondent. At the same time, the replies of these women to questions already answered by the "experts" could be compared with the psychiatrists' answers and matters on which all were agreed could be sorted from matters of disagreement and misinformation.

The numbers of women of the four types who were available were not large enough to allow of a random selection of respondents. Especially in the case of the upper class relatives of psychiatric patients, when the co-operation of clinicians was called for and there was a possible danger of arousing antagonisms, it took some time to obtain the requisite half dozen middle aged women.

In fact the women, once the interviews had begun[15], all proved/

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15 Conducted by the writer personally.

proved very co-operative and were actually anxious to supply more information than was called for. Unfortunately, however, since there was no means of excluding from groups (c) and (d) beforehand those women who had had personal experience of mental illness in a relative or acquaintance (as opposed to experience in the course of their work), these groups in fact proved to be "contaminated" to some extent.

By the time the second pilot interviews had been completed a number of lessons had been learnt. It had been realised, for example, how important it was to avoid a long prior discussion of the topic in hand since it would be easy to let slip, in the course of such conversation, the types of answers which would subsequently be "approved"; respondents did not realise the meaning of "certified", so this would require rephrasing; parts of the schedule could be better laid out for scoring purposes, and so on. But the main defect of the schedule lay in the continuing tedium of Question 8 and its sub-divisions. This section of the questionnaire was both tiresome to administer and boring to answer. Respondents tended to consider that they had already been reasonably co-operative by the time they had sorted the statement bearing cards. The repetitive and rather artificial quality of the next portion of the schedule was inclined to reduce their patience/

patience with the entire exercise and make their answers to the final questions perfunctory.

As far as the answers to the opinion and attitude statements were concerned there did appear to be differences in relation to experience and education. Some statements were eliminated at this stage because they had not elicited a wide enough range of responses[16]; some were altered in their wording to convey a more definite sentiment[17]; some were discarded on account of special criticisms from the psychiatrists[18]; in other cases all the groups of people, both lay and expert, were agreed and so an opinion statement was removed because it had failed to discriminate[19].

Stage 6 - Construction of the schedule in its final form for use in the Edinburgh survey

The ultimate form of the questionnaire can be studied in Appendix IV (p. 282). Headed in a non-commital fashion as a "Health Opinion Survey", it began with an assurance to the respondent of the respectability of the sponsors and the anonymity of all answers.

The diagnostic terms in Question 1 had now been reduced to eight in number and were presented on a card for checking.

Questions/

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16 E.g. A.8, A.11, A.12.

17 E.g. Part of A.2 was changed from "confined to hospital" to the more custodial phrase, "put away in institutions".

18 E.g. B.20, B.22.

19 E.g. B.29, C.36.

Questions on experience of mental illness, at first or second hand, followed before the main section of the schedule was reached.

As described above, the list of opinion and attitude statements had already been greatly modified. Opportunity was now made to utilise this section of the questionnaire for the inclusion of other subjects, previously treated separately. Thus, the previous complicated cross-examination centered upon social distance in relation to different index persons had now been abandoned. Instead, a series of simplified statements expressive of degrees of social distance had been scattered throughout this portion of the questionnaire. These were statements 6, 11, 15, 34, 37, 40 and 45. These would be treated by the respondents in common with all the other statements on cards and sorted according to the extent of their agreement or disagreement with the sentiments expressed.

The previously ambiguous question regarding certification had by now also been incorporated in this portion of the schedule, in the form of Statement 43 ("Most people in mental hospitals nowadays have gone in of their own free will".). The question of community tolerance (Statement 42) had been similarly dealt with.

Statements 44 and 46 had been introduced at the suggestion of Professor J. Ferguson Rodger of Glasgow that beliefs of this kind/

kind were prevalent.

The attempt to estimate peoples' regard for "the norm of self reliance" was now to be made by the use of the operative statement used by Phillips and which now constituted the final item[20] in this section of the schedule.

As possible relevant personality measures Eysenck's short form of the Maudsley Personality Inventory[21] was now chosen to follow the opinion and attitude section. It seemed that persons with a high score for neuroticism might perhaps be more sympathetic towards the mentally ill than low scorers. Possibly those who scored high for extraversion might have scant patience for psychiatric problems. This personality test had the advantage of being brief and easy to administer.

Demographic data had been requested in a form which made final scoring easier. The question (No. 12) relating to children under the age of fifteen, was inserted because it was thought that parents of young girls might be particularly cautious about ex-mental patients in the community. Questions of religious observance were introduced in the belief that practising Christians should give an example of sympathy.

Opportunity was given for the interviewer to record their impressions/

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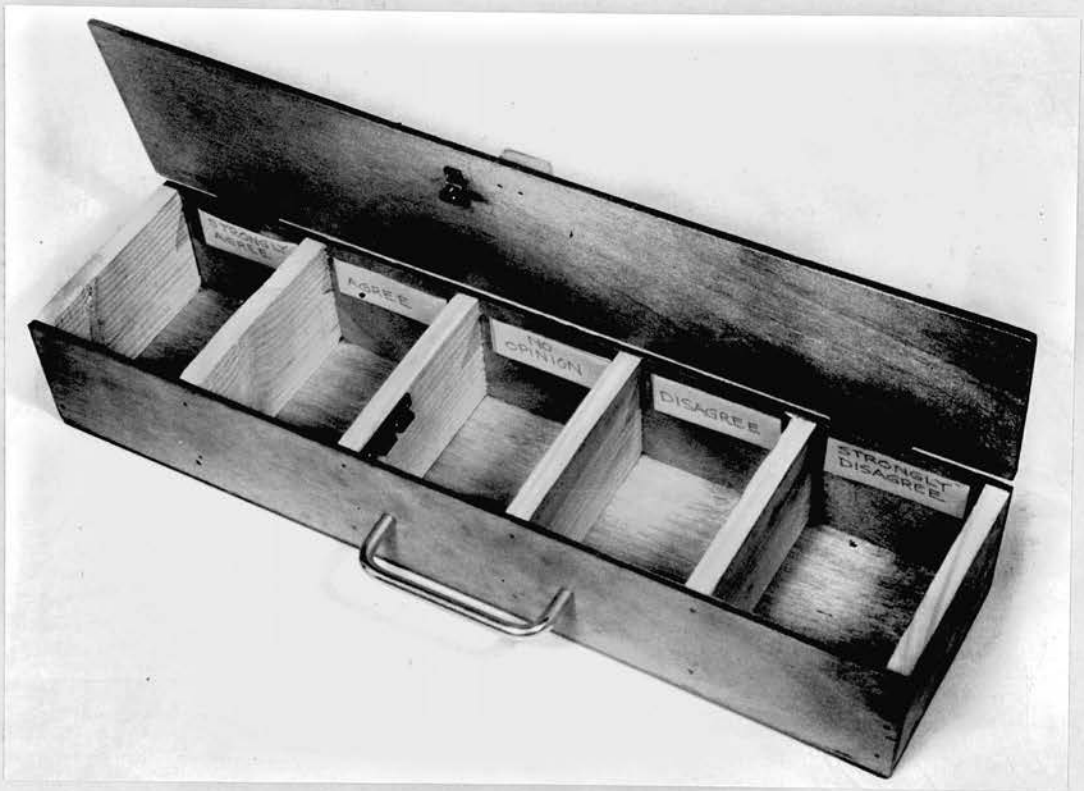
20 Statement 47, "I think that in general people should be expected to handle their own problems".

21 Eysenck (1958).

FIGURE 1



Wooden box divided into five compartments for sorting attitude and opinion statements.

impressions of the interview and to sign the schedule.

It now only remained to decide the actual mechanics of presentation of the questions and the method of scoring. Sets of special cards were printed bearing the Statements 1 - 47 which constituted Question 5. These would be introduced by a sample card relating to a completely different topic which would afford an opportunity for the interviewer to demonstrate the method[22]. For this purpose wooden boxes were constructed, specially designed to take sets of cards in five separate compartments. These compartments were clearly labelled, "STRONGLY AGREE, AGREE, NO OPINION, DISAGREE, STRONGLY DISAGREE". Respondents would sort the cards into the pigeon holes in the box. (See Figure 1 opposite).

There would be check lists on cards for Question 1 (the diagnostic terms) and for Question 8 (age groups).

Respondents would be required to score Question 6 (M.P.I.) personally.

The rest of the schedule would be administered orally by the interviewers in the form in which the questions were phrased.

Stage/

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22 The use of cards was a modification of a technique used by Rawnsley who had employed one form of this mode of presentation in a survey in Glamorgan (see p. 122 above).

Stage 7 - Details of Scoring Methods

For much of the schedule the scoring consisted, in the first place, in indications made by the interviewer as to which of a series of possible answers the respondent had given. The replies could thereafter be transformed, by means of a convenient code, into data for punching on E.C.T. cards. This applied, for example, to Questions 2, 2a, part of Question 3, part of Question 4 and 4a, Questions 7, 8, 9, 12, 13, 14a and 15. Examination of the schedule will indicate the categories used in each of these instances.

Other answers had not been entirely predetermined or precoded, however. In these cases the interviewer was to record the respondent's reply which would later be coded. Such questions were the second part of Question 3, part of Question 4a, Questions 10[23], 11, 14, part of 15 and 15a. Question 16 was entirely openended and would require content analysis eventually.

There remained Questions 1, 5 and 6. In regard to Question 1, the initial responses were in the form of a ranked series of numbers from one to eight. Since the main interest centred upon the three diagnostic terms relating to psychiatric disorder and to the other probably anxiety provoking term, "cancer", for purposes of final analysis only these four terms would be considered. A respondent's ranking of eight separate terms would thus be reduced in the code to their ranking of mental/

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23 Occupation was to be transformed, in the first instance, into the Registrar General's Social Grades I to V.

mental illness, nervous breakdown, insanity and cancer.

The section of the questionnaire relating to opinions and attitudes (Question 5) had been designed to allow for responses on a five point scale from 5 to 1[24]. The higher score in each instance was awarded to the answers which showed, respectively, greater sympathy, readiness to tolerate a closer degree of social intimacy and (in the case of the opinion statements answered by experts) agreement with the views of the majority of the consultant psychiatrists. The final question, relating to self reliance, was scored high for agreement.

Only some of the statements, however, were to be employed in the construction of scales. In the first place there was a 'Sympathy Scale' consisting of responses to eight statements, namely, 1, 2, 3, 4, 5, 7, 13 and 14. In the case of statements 7 and 14 agreement scored high, whereas with statements 1, 2, 4, 5 and 13 agreement scored low. The range of possible scores was thus from 8 to 40.

Contained within this portion of the schedule were also the seven statements of social distance, namely, 6, 11, 15, 34, 37, 40 and 45. Since agreement with all of these could not be regarded as equivalent, they were differentially weighted for scoring/

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24 It should perhaps be pointed out here that the respondents' sorting of cards into boxes was to be translated by the interviewer later into scores on the schedule pages relating to Question 5.

scoring purposes to construct a 'Social Distance Scale'. Thus responses to Statements 34 and 37, indicative of minimal intimacy, received the general level of scores from 5 to 1, with "strongly agree" scoring 5. Statements 15, 40 and 45, representing closer intimacy, had the scores doubled, from 10 to 2, with "strongly agree" scoring 10. Statements 6 and 11 proposed the closest social intimacy and accordingly had the scores trebled, from 15 to 3, with "strongly agree" scoring 15. On the Social Distance Scale there was accordingly a possible range of scores from 14 to 70.

Responses to all forty-seven statements could be analysed in terms of the percentages of the sample population, or any special sections of it, which agreed or disagreed with them. The scores of respondents for "sympathy" and "social distance" could also be related to a very wide range of variables, including not only such items as age, sex, experience and education, but also their answers to other portions of the questionnaire, including replies to other opinion or attitude statements.

For the actual process of estimating the scores, transparent score sheets were constructed for each scale which could be either laid over the appropriate portion of the schedule or used for easy reference. Special sections of the code, following Question 5, allowed for recording the respondent's score/

score on both these scales.

Question 6 consisted of the first twelve questions of the Maudsley Personality Inventory. The appropriate transparent scoring keys were to be employed for this purpose in accordance with the printed instructions. The code sheet for the schedule allowed for recording the respondent's score on the N and E scales respectively.

To summarise, the schedule would be filled in the first place by the interviewer, except for Question 6 which was to be handed to the respondent to complete. It would also be the interviewer's responsibility to transfer the respondent's reactions to the forty-seven statements, expressed by sorting the cards into boxes, into the form of responses on the sheets relating to Question 5.

Subsequently, using a specially designed code, all the information would be converted[25] into a form appropriate for transferral to the eighty columns of an I.B.M. punch card. Allowance was also made for possible subsequent computer analysis of the data by minor modifications in the code.

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25 By the principal investigator.

CHAPTER VI

THE METHOD OF THE EDINBURGH SURVEY (CONTD): THE SAMPLE AND THE INTERVIEWERS

The Sample

Considerations of cost limited the size of the sample which could be drawn to 500. This would represent just over one per cent of the Edinburgh population[1].

At first, attention was directed to the possibility of using a stratified sample. There were two possible approaches to this. The first had been indicated by Gray and Blunden (1957) who suggested the use of two indices in urban areas, the rateable value per elector and the industrialisation index for each ward. These could be used to rank a town like Edinburgh according to a rough social class gradient.

Cartwright, Martin and Thomson (1959) in the conduct of a survey on smoking habits in Edinburgh, ranked the twenty-three wards of Edinburgh in order of overcrowding before drawing the first stage of their sample.

Dr. Keith Hope, of the Medical Research Council Unit[2] in the/

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1 Population in 1961 Census - 468,361.

2 From which the research was taking place.

the Department of Psychiatry advised against the use of a stratified sample, however, on the grounds that the necessary information was missing, both in relation to the proportions of the population falling into the different strata, and in relation to the individual members of the sample (since the electoral register could, in most cases, merely register sex). There would be further difficulties of a statistical nature on account of lack of information about the variances of the variates. Only an antecedent random sample could afford all the information required and, since this was not at present available, the proposed survey should aim at a random sample in the first place.

Picking a one per cent sample direct from the electoral register promised to be a time consuming task. There was, however, available a group of first stage units small enough to provide reasonable homogeneity and which had already been successfully used in an on-going study of the disabled in their homes by Mr. Stanley Sklaroff, a statistician in the Department of Social Medicine. The first stage units were the 830 Census Enumeration Districts for the City of Edinburgh. Eliminating those which contained no residential sections, twenty-five of these districts were chosen from this frame using a table of random numbers.

The districts were small, consisting of only a few streets each./

each. The next stage consisted in drawing, from the map, the longest street in each selected district. The reason for this decision was that the electoral register, from which the ultimate sample would be drawn, is arranged in streets and it might be more convenient for the interviewers to work along the dwellings in one street. It was thought that the small size of the first stage units would permit of this choice.

The Electoral Register was then consulted and again a table of random numbers was used. Respondents were chosen at randomly selected intervals to a total of twenty in each district. In some instances as when, for example, the street was too short or proved to contain too many commercial or institutional buildings to allow of the full twenty being drawn, the number was made up from the names on an adjoining street.

It should be pointed out that Y (under twenty-one) and Service voters were ignored when taking the random sample from the Register. A further point concerns the date at which the sample was drawn, this was in mid-May, 1966, the information on which the Register was based having been collected in the previous October. The sample was chosen immediately before the interviewers went into the field, in the last week of May, 1966.

Once the interviewers were ready it only remained to allot to them at random the lists, which each now contained twenty named/

named respondents.

The Interviewers

Since it was not feasible for the principal investigator to carry out 500 interviews in a short period of time, interviewers were recruited from among a group of women previously employed on survey work by the University Department of Social Medicine. They had all been personally recommended by the Department and were interviewed separately to assess their suitability for the work. When four women of appropriate experience and references had been chosen their number was made up to five by a very competent secretarial employee of the M.R.C. Unit (Miss A.) who had been closely concerned in the planning of the survey from its earliest stages and to whom it was desired to offer some wider experience of field work. Being at this time inexperienced in interviewing, she was embarked forthwith upon a series of twelve trial encounters in one of the central wards of the City.

Arrangements were made to meet the other women for a series of explanatory and training sessions. On these occasions the aims and methods of the proposed interviews were explained to them at length, and they were introduced to the schedule, the packs of cards and the boxes which they would carry with them. The various pitfalls of interviewing were discussed at some length, great stress being laid upon the importance of interviewing/

interviewing the designated respondent and no substitute, on the uniform presentation of all the schedule items, and on the particular necessity to avoid any alteration in the phraseology of opinion questions.

These various lessons had also been written down in some detail in a Manual for Interviewers (see Appendix V) which had been specially compiled for this survey[3]. The interviewers were to study the manual carefully and to carry out five practice interviews among their acquaintances. They were then given an opportunity to demonstrate their conduct of the interview before the other members of the group.

One modification of technique was introduced after the manual had been printed, this related to the scoring of Question 5 (sometimes referred to as Section 5)[4]. Instead of the interviewers transferring the piles of cards, "from five marked boxes into five appropriately marked and numbered envelopes", they were to leave the piles of cards in the

divisions/

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3 Acknowledgement of assistance in the matter of interviewer training and the preparation of instruction manuals must be made to Dr. S.P.W. Chave, who made a number of valuable suggestions and who supplied a copy of the confidential, "Notes for Interviewers" used in the Harlow Health Survey, 'Mental Health and Environment' (1964); to Mr. H.W. Biggs of Research Services Limited who supplied their private, "Field Workers Manual", and to the Institute for Social Research, University of Michigan, Ann Arbor, for the Survey Research Centres, "Manual for Interviewers". The"Handbook for Interviewers" of the Social Survey, edited by Muriel Harris (1950) was also consulted.

4 See the section of the Manual headed, 'Recording Replies'.

divisions of the specially designed box in which the respondent had placed them. At a later stage in the day, once the interviewer had reached home, the piles of cards were to be taken out and the answers scored in the appropriate columns of the score sheets relating to Question 5.

The wooden box had been made deep enough (see Figure 1, opposite p. 143) to accommodate several packs of cards, the product of several interviews. Confusion between the results from separate respondents was to be avoided by the use of differently coloured divider cards, numbered from 1 to 5. When the first respondent of the day had sorted his pack the interviewer was to place a coloured card marked "I" on the top of each small pile. The next respondent could then sort his pack on top of the preceding piles, which in turn were capped with a coloured card marked "II" and so on. The interviewer kept a note on a daily quota sheet relating schedule numbers to respondents' names and addresses and also recording the order of each interview in the day's programme. The interviewer could thus complete a total of five interviews in one session, carry home the box, and subsequently remove each pack of cards in turn for scoring onto the appropriate schedule.

Armed with five packs of printed cards each, check list cards, coloured divider cards, a portable wooden box, quota sheets (allocated at random), numbered blank schedules, daily quota/

quota recording sheets, weekly expense sheets, and a letter of authorisation, the interviewers were ready to go into the field by 30th May, 1966.

It was hoped to complete the field survey during June and early July, so as to anticipate the possible departure of some respondents on summer holiday. In the event, however, not all interviewers worked equally fast and the survey was not completed until 3rd August. The last two weeks of this period was occupied in extra calls back by one of the interviewers (Miss A., the secretary mentioned above) at the homes of half of the respondents whom the other interviewers had reported as being out (after at least three calls) and at the homes of all respondents who had been previously reported "on holiday".

Shortly after the outset of the field survey two interviewers dropped out, one through illness (Mrs. K) and one because her permanent employers, the Government Social Survey, had raised objections to her taking on part-time work (Mrs. W). The quotas remaining from these two interviewers were redistributed among three further interviewers, who were only appointed after undergoing a similar course of instruction to the initial group. Thus the total number of interviewers eventually employed upon the Edinburgh Survey was eight[5].

Close/

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5 Coding of the schedules made provision for indicating the interviewers responsible.

Close contact was maintained with all the interviewers throughout the field survey. They submitted completed schedules twice weekly, together with the relevant daily quota sheets. On the latter they were also required to record the reason for any failure to interview a specified respondent (a specimen daily sheet is in Appendix V, p. 319). In discussion with the interviewers any ambiguities relating to the explanation for these failures were resolved.

The schedules from each interviewer were scrutinised on receipt. The very considerable variation in answers on successive schedules from each interviewer did not suggest that there had been attempts to fabricate replies. This impression of the interviewers' honesty was further substantiated by the considerable circumstantial detail which they often recorded in the "Comments" section at the end of the schedule, and which they brought up in the course of conversation about their progress.

In the course of the field survey the impression was gained that the most difficulty in locating respondents seemed to be occurring in these districts of the town known to contain a high proportion of substandard, tenement housing, areas which the Council of the City of Edinburgh were currently engaged in clearing.

If, after three calls, a respondent was not located no systematic attempt was made to trace the person concerned (apart/

(apart from the late July and early August calls of Miss A., mentioned above). To have traced the whereabouts of persons who had moved, either on their own accord or consequent upon the allocation of new Council housing, would have involved considerable labour. The search for such missing respondents could, moreover, have gone on for a period of some months, introducing difficulties in the employment of the interviewers and also increasing the possibility of further loss from this evasive group of respondents through illness, accident or death. It therefore seemed preferable for all these reasons, and also to avoid temporal drift, to concentrate the enquiry during six weeks of the summer of 1966, particularly since the Electoral Register, from which the sample had been drawn, was already at the commencement of the survey, eight months out of date.

CHAPTER VII

THE RESULTS OF THE EDINBURGH SURVEY

INTRODUCTION

In this chapter the results of the Edinburgh survey will be summarised in a number of separate sections. The bulk of the Tables which illustrate these results are to be found in Appendix VI pages 320 - 382, to which reference should be made for all the more detailed evidence. In that Appendix the relevant Tables have also been arranged in sections. Not all the tabulations or calculations which were actually undertaken appear in the Appendix, however, a prior selection having been made to eliminate a number of unsignificant findings. Occasional summary tables will be introduced into the text to illustrate particular points.

SECTION 1

THE SAMPLE

It had been the original aim of this survey to interview a random sample of 500 Edinburgh adults. In the event, the number of completed interviews was 373.

The interviewers reported a wide variety of reasons for failure to interview the chosen respondents. Some people were unobtainable due/

due to death or disability, some were out upon all the occasions when they were sought and five were on holiday. The two largest categories of loss were people who had moved (total forty-four) and those who refused to be interviewed (total thirty-two).

The policy regarding persons who had moved, leaving no trace of their subsequent address, was outlined in the last chapter. Therefore, a total of fifty-four out of the initial sample of 500 were no longer available for interview, having died or left, permanently or temporarily, their specified address. If, following the example of Cartwright, Martin and Thomson (1959) in their Edinburgh survey of smoking habits, these people are excluded, the number of persons available for interview at the time of the survey is reduced to 446. Out of these 446 individuals, the total finally interviewed was 373, giving a success rate of 83.6 per cent.

The number of outright refusals amongst the 446 available members of the sample was thirty-two, a refusal rate of 7.4 per cent. For the previous Edinburgh survey the reported success rate was 85 per cent for adults and the refusal rate was 5 per cent

SECTION 2

COMPARISON OF SAMPLE WITH CENSUS

The Edinburgh sample consisted of 167 males and 206 females, giving a female:male ratio 1.23: 1.00.

In the Edinburgh Census of 1961, among persons over the age of twenty, there was a total of 146, 750 males and 182,586 females. The/

The female:male ratio was 1.24; 1.00.

Table 3 in the Appendix compares the percentage of adult males in the survey sample with those of the 1961 Census and Table 4 makes the same comparison for females. The Census figures begin at age twenty, those of the sample at age twenty-one.

Among the men, the main deficiencies in the sample were in the under thirty-fives, away at work by day and often out in the evenings also. The sample of women was short of those under twenty-five. There was a relatively high proportion of women from that age until the age of forty-nine, more easily accessible because of domestic duties, but there was a shortage of the most elderly women, possibly because of infirmity and reluctance to co-operate.

SECTION 3

FURTHER CHARACTERISTICS OF THE SAMPLE

Three quarters of the sample were married.

Social Class was initially expressed in terms of the Registrar General's five classes. Married women were classified by their husbands occupation. Women in employment were also classified according to their own job. The majority of respondents were in Social Class III.

Education: The respondents were originally classified into a large number of categories according to their educational level. In summary, over three quarters of the sample had not been educated beyond secondary modern (junior secondary) level whilst one third had/

had only received a primary education. People reporting any kind of post secondary education constituted less than six per cent of the total.

Personal experience of the mentally ill: This was reported by more than half of the sample. Six per cent reported that they themselves had once been mentally ill.

Visits to mental hospitals were mentioned by almost 41 per cent of the respondents. Most of these were referring to Edinburgh hospitals, including Bangour which is not strictly within the city. The majority who had been inside a mental hospital had visited comparatively recently, within the last ten years. These facts are detailed in Tables 11 to 15.

Information: Recently acquired information on the subject of mental illness was reported by nearly 60 per cent of the respondents. The topic had mainly been encountered on television, and the mass media generally were the source quoted by 86 per cent of those with recent information (Tables 16 and 17).

Further probing to elicit the precise nature or content of particular programmes or news items did not produce useful information as most people were very vague on details.

Religion: One hundred and ninety-five respondents had some connection with a Protestant church and forty-two went to mass. Most of the Protestants were "occasional" attenders, i.e. less than once a month, whereas the Catholics were mainly "regulars", going/

going once a month or more. Over a third of the sample never went to church (Table 18).

Respondents' scores on the short form of the Maudsley Personality Inventory:

The scores obtained on the neuroticism scale are shown in Table 19. The mean score was 5.57 and the standard deviation 3.74.

Scores on the extraversion scale are listed in Table 21. The mean score for extraversion was 7.01 and the standard deviation 3.11.

Tables 20 and 22 indicate the distribution of the neuroticism and extraversion scores in terms of the percentages of the population obtaining particular scores.

The findings in this survey can be compared with those of Eysenck (1958) and Shaw and Hare (1965).

Summary Table 1 A comparison of three studies of the short Maudsley Personality Inventory

	Eysenck English Quota Sample	Shaw and Hare Urban Population Sample	Edinburgh Sample
Extraversion			
Mean score	7.96	6.93	7.01
Standard deviation	2.97	2.91	3.11
N	1,600	1,857	372
Neuroticism			
Mean score	6.15	5.10	5.57
Standard deviation	3.42	3.45	3.74
N	1,600	1,857	372

The/

The mean scores of the Edinburgh sample results fall mid-way between those of Eysenck and those obtained by Shaw and Hare in Croydon. A higher proportion of the Edinburgh sample obtained scores in the top range for neuroticism than was the case in Croydon. The distribution of the neuroticism scores was further from a normal distribution than was the distribution of extra-version scores.

Children in household: One hundred and seventy-two persons reported the presence of a child under the age of fifteen in the household. One hundred and ninety-nine had no such household member and two did not reply.

Respondents' recipes for avoiding mental illness: A wide variety of suggestions were offered regarding supposed means of avoiding mental illness. The list of proposals was not subjected to content analysis, but the following answers of a one in ten sample of the respondents conveys some idea of the flavour of this segment of present-day folk lore.

"RECIPES FOR AVOIDING MENTAL ILLNESS"
AS PROVIDED BY ONE IN TEN OF THE EDINBURGH RESPONDENTS

1. Male. Married. 65 - 69. Odd job man in boarding school.
"Stay out of trouble and keep away from the police".

2. Female. Widowed. 65 - 69. Husband was a motor mechanic.
"Don't worry; worry is the cause of that sort of trouble, the main cause".

3./

3. Male. Married. 50 - 59. Flour packerman.

"Awkward questions to ask a layman. I wouldn't think I was qualified to answer that. Keep happy. Stop yourself getting gloomy or something like that. Keep your pecker up".

4. Female. Single. 70 - 74. Former paper factory employee.

"Company helps. If you have no worries in your work, if you are working. I didn't have worries. People to help you, to advise you".

5. Female. Widowed. 50 - 59. Office cleaner. Husband was a builder's labourer.

"I think you just have to face things. You have to put on a front. When my husband died I had to face it".

6. Female. Married. 30 - 34. Husband a compositor in printing works.

"Be able to accept what happens to you, to make the most of what you have".

7. Female. Married. 60 - 64. Shop assistant. Married to warehouseman.

"I think taking things in your stride and considering things carefully and not living beyond your income".

8. Female. Married. 55 - 59. Husband a plumber.

"Not to moan about things - keep active and have outside interests".

9./

9. Female. Married. 30 - 34. Husband, chief steward.

"Don't let everything get on top of you - go through life without any worries. Don't buy what you can't pay for".

10. Male. Married. 40 - 44. Engineering mechanic.

"Keep occupied and don't give yourself too much time for worrying and brooding over things".

11. Male. Widowed. 40 - 44. Dock labourer.

"To have plenty work to keep your mind occupied".

12. Male. Married. 40 - 44. Clerk.

"Good home life and happy life".

13. Female. Widowed. 55 - 59. Husband second mate in Merchant Navy.

"Peace and quietness. (p). Not living alone - live with someone and be sociable. (p). Listen to some music and and healthy life. Someone to care for you and kindness is the best, I think, to avoid it".

14. Female. Married. 25 - 29. Husband a policeman.

"Don't let things get on top of you. Keep calm".

15. Male. Married. 60 - 64. Foreman in warehouse.

"My opinion. Never get worried. Keep on the bright side - mix with people. Be a member of a club and have an interest in life. Don't lounge about".

16. Male. Married. 55 - 59. Private gardener.

"Don't worry too much".

17. /

17. Male. Married. 45 - 49. Plumber.

"Don't exert yourself and try not to worry about other people. Try to take things easily - it's a lot for one with hustle and bustle in the world nowadays".

18. Female. Single. 55 - 59. Bottle washer.

"To get out in the fresh air and meet people - not sit indoors and worry about things".

19. Polish woman. Married. 45 - 49. A bus conductress. Husband a conductor.

"I don't think you can - I was taken away from my home by the Germans when I was seventeen and never saw my mother again and lived through some terrible things and even when I came here we had some hard times but my husband and I have worked hard and now we have a fine home and family and are very happy but some people just wouldn't have been able to take what we have - we are all made differently and you can't help it any more than you can help what you look like".

20. Male. Married. 50 - 54. Technical officer in G.P.O.

"Happy, contented life if you can get it".

21. Female. Married. 50 - 54. Husband a joiner.

"To have a full life - to avoid boredom".

22. Female. Married. 35 - 39. Husband owns retail food shops.

"Shouldn't worry - be happy in your home life".

23. /

23. Female. Married. 75 - 79. Husband was a dock labourer.

"Avoid irritation and being kind and avoid cruelty and help people who need it".

24. Female. Married. 55 - 59. Husband a warehouseman.

"Keep your mind and your hands busy and be cheerful".

25. Male. Married. 60 - 64. Electrician.

"Live a decent life, be sober, not to drink and smoke".

26. Female. Married. 25 - 29. Sales agent. Husband a grate builder.

"Keep active and don't get too much into yourself but don't be over-active. Try to keep as happy as possible - keep on the cheery side. Have a hobby - something creative. Boils down to not thinking too much of yourself. Talk to people. Try to keep healthy otherwise don't think about it".

27. Female. Widowed, (two children under fifteen). 44 - 49. Husband was a cook.

"Take things easy. No worries".

28. Male. Single. 50 - 54. Warehouseman.

"I couldn't say. It's not good telling lies, when you don't know anything about it".

29. Male. Married. 55 - 59. Milk checker in dairy.

"To avoid any youngsters having mental illness, should be brought up in a happy atmosphere, unless its something pre-birth. This goes for adults as well".

30./

30. Female. Married. 40 - 44. School cleaner. Husband in foundry.

"Hard work, and keep going".

31. Female. Single. 21 - 24. Occupation, medical student.

"I don't think you can avoid it by any particular efforts of your own".

32. Female. Married. 45 - 49. Husband an upholsterer.

"Environment, I think it's the way you are brought up. When you grow up you are apt to dwell, and look back on this".

33. Male. Married. 45 - 49. Civil engineer.

"The best way is if you have any problems, discuss them with someone. Don't bottle them up".

34. Female. Separated. 30 - 34. Husband a fireman, lives with his mother. Sees family occasionally.

"A happy home life. Life is just what you make it yourself".

35. Female. Married. 35 - 39. Husband works in a rubber mill.

"Not to get too over-excited, and to take things easy, and don't worry. Worry can put you over the bend".

36. Female. Single. 45 - 49. Secretary at Gogarburn Hospital for mental defectives.

"Mental illness is something that can happen to any body. A diffifult question to answer. An awful lot depends on the/

the person themselves, their character. Some people have a weakness- more easily swayed, can't cope; things get too much for them".

37. Male. 21 - 24. Housepainter.

"Being allowed to live with peace of mind. Managing to have as little mental and physical stress as possible, and having enough freedom to do particular things that you may want to do".

SECTION 4

QUALITATIVE DATA RELATING TO ATTITUDES AND OPINIONS REGARDING MENTAL HEALTH

I Ranking of diagnostic terms

The four conditions, cancer, insanity and mental illness had, along with further four diagnostic labels, been ranked by the respondents in order of seriousness or dreadfulness. People had been asked to say which condition they themselves would least like to have and to order the others in succession. Only cancer and the three terms relating to psychiatric disorder were considered in the analysis.

Cancer was the condition most feared, 200 respondents or 54.2 per cent of the sample, placing it first in order. The mean ranks were as follows:

Cancer/

Cancer	1.72
Insanity	2.09
Mental illness	2.49
Nervous breakdown	3.40

Thus, as had been hypothesised, the term "mental illness" was classed by the sample as lying in between "insanity" and "mental illness".

II Statements of attitude and opinions regarding mental illness and the mentally ill

The 47 statements of attitude and opinion regarding mental illness and the mentally ill constituted the core of the enquiry. Although the responses to this portion of the questionnaire are somewhat lengthy they have been reported in full in the appropriate section of the Appendix (Tables 23 to 69). What relationships, if any, obtained between the responses to certain particular statements and other variables such as age, experience, educational level and so on, will be considered subsequently.

In reporting the responses to individual statements the percentage of respondents expressing each degree of agreement or disagreement has been indicated, although for the later analysis it proved more convenient to reduce responses to three categories, namely, 'agree', 'no opinion' and 'disagree'.

Extracting some of the features of public opinion in this area, it/

it appears that 75 per cent of people think of the mentally ill as being emotional, although only 33 per cent would actually regard them as dangerous. Nearly 60 per cent view them as unreliable and the same proportion believe that they are liable to commit suicide. People are equally divided (43 per cent, 44 per cent) upon the question of whether the mentally ill should be "put away" in institutions, but the majority (94 per cent) approve of the more humanely phrased suggestion that immediate hospital treatment for mental disturbance is desirable.

As far as the manner of entering hospital is concerned, 60 per cent of the sample agree that most people in mental hospitals nowadays have gone in of their own free will. There is some uncertainty over the prevailing conditions of custody, but as many as 35 per cent still believe that most mental patients are kept in hospital against their will. The possibility of release from hospital seems to be appreciated, since 73 per cent would not agree that "few people who enter ever leave". But nearly 57 per cent of the sample think that many patients who do leave will return for more treatment at a later date.

The subject of mental illness is no longer taboo, 70 per cent disagree that "it is best not to talk about it"; people are fairly complacent about the present level of tolerance towards the mentally ill; 76 per cent disagree that the mentally ill should not be allowed to mix with ordinary people. The question of tolerance is considered at greater length later, in relation to the Social Distance Scale.

Popular/

Popular ideas (supported by 80 per cent or more) of the causation of mental illness are job worries, overwork and "the stress and strain of present day living". Money worries also rank high and an unhappy home life is perceived by 65 per cent as one of the main causes of mental illness. Nearly 70 per cent of the respondents believe that lack of affection in childhood may lead to subsequent mental illness. Drink is not recognised as a large contributor to mental illness, and physical causes, such as accidents and illness do not rate high in the general view.

SECTION 5

THE COMPARISON BETWEEN POPULAR AND PSYCHIATRIC VIEWS

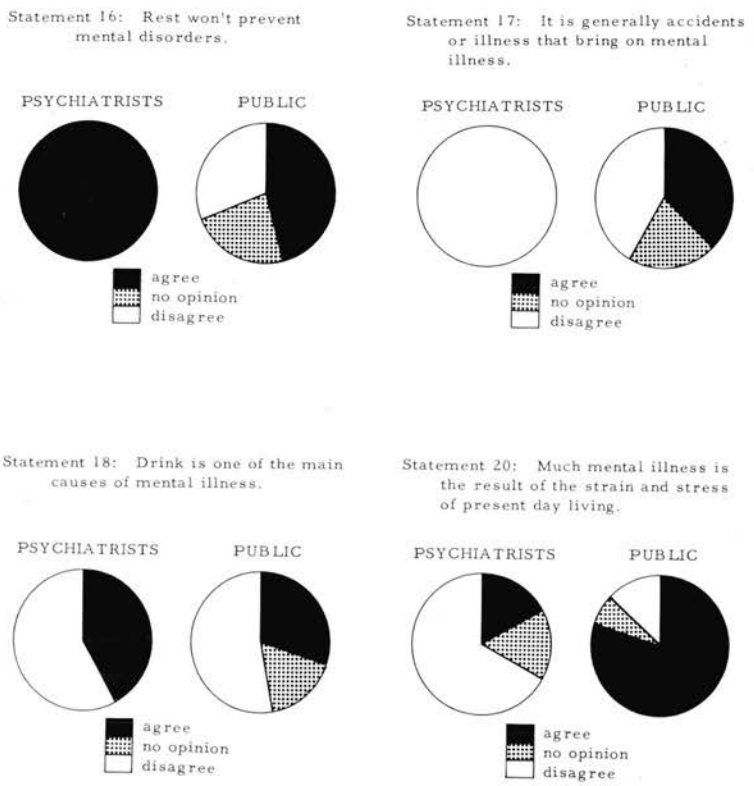
Although the group of psychiatrists whose opinions were obtained was a very small one (12), it is nevertheless of some interest to compare some aspects of the popular picture of the causes and course of mental illness with this specialist point of view.

Table 70 in the Appendix lists those statements on which there was practically a consensus of psychiatric opinion, with over 90 per cent of the small group of twelve Scottish consultants in agreement, whilst Table 71 indicates five statements which led to agreement among a majority of the psychiatrists.

The specific comparison between public and psychiatric opinion is made in Table 72 and the comparisons are graphically illustrated in Figures 2 to 5 .

As/

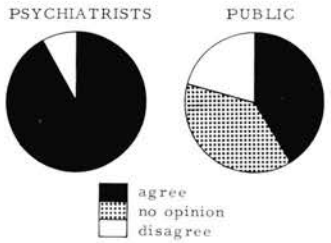
FIGURE 2



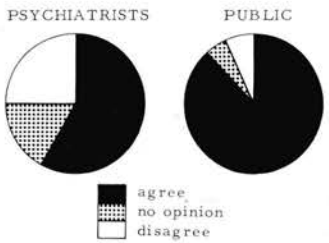
Comparison of the views of psychiatrists and public upon aspects of mental illness.

FIGURE 3

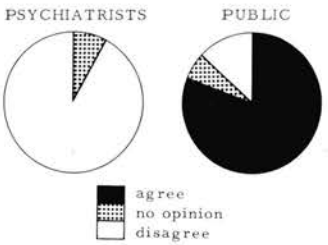
Statement 21: A change of climate seldom helps a developing mental illness.



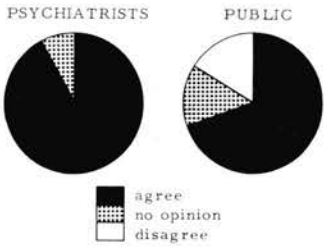
Statement 22: Job worries can bring on mental illness.



Statement 23: Overwork is a big cause of mental illness.



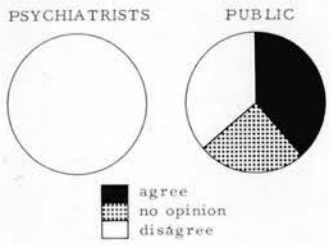
Statement 24: Children who are made to feel they are not wanted may develop mental illness when they grow up.



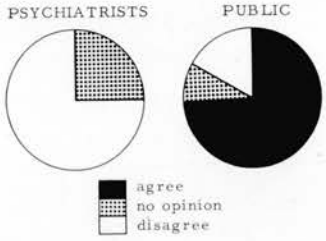
Psychiatric and popular views (continued).

FIGURE 4

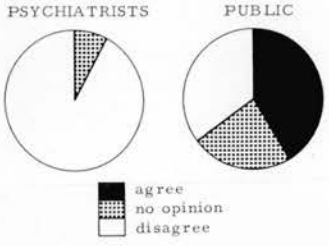
Statement 25: Mental illness can be avoided by avoiding gloomy thoughts.



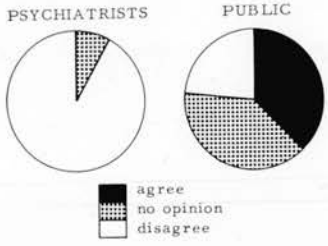
Statement 26: Money worries are a big cause of mental illness.



Statement 27: One of the main causes of mental illness is lack of moral strength.



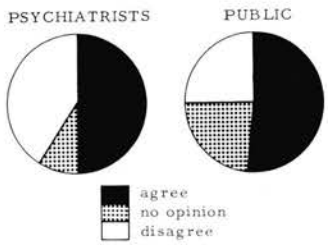
Statement 28: Sexual over-indulgence will end for some people in mental illness.



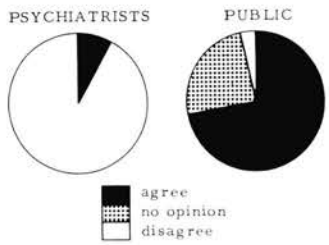
Psychiatric and popular views (continued).

FIGURE 5

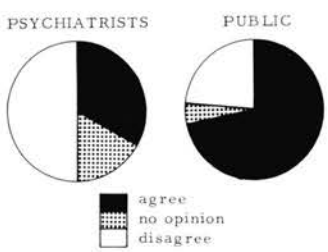
Statement 29: Mental patients usually settle back into ordinary life again quite easily when they are discharged from hospital.



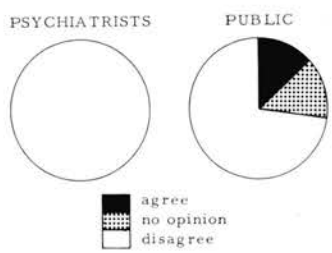
Statement 30: Mental illness can often be helped by a holiday or change of scene.



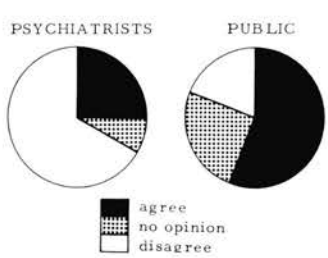
Statement 31: To develop a mental illness is one of the worst things that could happen to anyone.



Statement 32: Few people who enter a mental hospital ever leave it.



Statement 33: Many of the mentally ill people who seem to be better will be back for more treatment later on.



Psychiatric and popular views (continued).

As might have been anticipated, the specialists, from their privileged viewpoint, were more inclined to be definite regarding matters upon which ordinary respondents were often not prepared to venture an opinion.

There was a considerable difference between popular and psychiatric views regarding initial retention in hospital and the prospects of subsequent re-admission, the specialists being more optimistic about these matters. Some of the public still fear admission as either an irretrievable step or, at the least, an indication of persistent disability. The public tend to see the causes of mental illness as lying largely in external circumstances and being amenable to changes in the conditions of life.

It should perhaps be recalled here that the statements relating to the causes, course and prospects of cure of mental illness were deliberately reduced in the pilot stages of the survey to a brief list which would point the differences in outlook between specialists and others. The result has inevitably been an oversimplification which can scarcely do justice to the sophistication and complexities of present day psychiatric theory.

SECTION 6

THE RELATIONSHIP BETWEEN RESPONSES TO SPECIFIC OPINION/ATTITUDE STATEMENTS AND CERTAIN CHARACTERISTICS OF THE RESPONDENTS

Respondents' reactions to some of the opinion and attitude statements/

statements were considered in relation to a number of variables which might have influenced their responses. By no means all of the statements were analysed in this way, nor are all the results which were obtained presented in this report. The statements analysed here have dealt mainly with the dangerous and unreliable attributes of the mentally ill and the manner of their custody.

In the Table below (not reproduced in the Appendix) the more notable findings of this section of the enquiry have been summarised. For simplicity the subject matter of particular statements has been greatly condensed but the relevant statement number is supplied in brackets. Reference to the Appendix (Tables 73 to 98) will supply the quotations in full as well as the actual levels of significance.

Summary Table 2

The Relationship between Respondent Characteristics and information or opinions on Mental Illness and the Mentally Ill

Respondent Characteristic	Subject Matter	Significance
Personal Experience of the Mentally Ill	Potential Danger (No. 1)	n.s.
	Potential Unpredictability (No. 41)	n.s.
	Advisability of Immediate Hospital Treatment (No. 7)	n.s.
	Prevalence of Voluntary Admission (No. 43)	sig.
	Necessity for Enforced Custody (No. 9)	n.s. [1]
	Likelihood of Eventual Discharge (No. 32)	n.s.

Voluntary/

1 Almost significant.

Respondent Characteristic	Subject Matter		Significance
Recent Information on Mental Illness	Voluntary Admission (No. 43)		n.s.
	Enforced Custody (No. 9)		n.s.[2]
	Taboo Topic (No. 5)		n.s.
Age	Potential Danger (No. 1)		sig.
	Potential Unpredictability (No. 41)		sig.
	Mental Illness a Taboo Topic (No. 5)		(highly) sig.
	Sexual Overindulgence a Cause (No. 28)		sig.
Sex (Female)	Potential Danger (No. 1)		n.s.
	Taboo Topic (No. 5)	(highly)	sig.
	Sexual Overindulgence a Cause No. 28)	(highly)	sig.
	Ex-mental patient Suitable Teacher (No. 40)		n.s.
	Female Ex-patient Suitable Baby sitter (No. 6)		n.s.
Education	Potential Unpredictability No. 41)		n.s.
	Enforced Custody (No. 9)		n.s.
	Taboo Topic (No. 5)	(highly)	sig.
	Sexual Overindulgence a Cause (No. 28)		sig.
Endorsement of Self Reliance	Lack of Moral Strength a Cause (No. 27)		sig.
Religious Affiliation	Lack of Moral Strength a Cause (No. 27)		n.s.
Belief in Restraint within Hospital (No. 9)	Likelihood of Eventual Discharge (No. 32)		(highly) sig.

It/

2 Almost significant.

It will be seen that lack of personal experience did not significantly increase peoples' tendency to regard the mentally ill as dangerous nor did experience modify their tendency to consider such individuals unpredictable and unreliable.

Personal experience was significantly related to knowledge about the prevalence of voluntary admission procedures and was almost significantly associated with correct information regarding current conditions of custody within hospitals. Similarly, recently acquired information increased respondents' knowledge about conditions within hospital to an almost significant extent.

The older the respondents the more inclined were they to view the mentally ill with dread and suspicion, to dislike discussion of the whole topic of mental illness and to cite sexual overindulgence as a cause of this affliction.

Women were significantly less likely than men to discourage discussion of mental illness and were more likely to reserve their judgement as to whether sexual excess played a part in its development. They were not more inclined to fear the possible danger from mentally ill people. Readiness to envisage an ex-mental patient as a teacher or reluctance to contemplate them in the role of baby sitter was not modified significantly by the sex of the respondent.

Those with an education[3] beyond primary level were significantly less/

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3 There was a close association between age and education level. When education up to or beyond primary level was considered in relation to age below or over 50 years,

chisquare = 56.73, df.1, $p < .001$

less likely to indict sexual overindulgence in the causation of mental illness or to discourage discussion. Increased education did not however significantly reduce peoples' tendency to think the mentally ill were unreliable and unpredictable.

People who agreed strongly with the ideal of self-reliance as expressed in statement 47 ("I think that, in general, people should be expected to handle their own problems") also held to the view that "one of the main causes of mental illness is lack of moral strength". But religious affiliation was not significantly related to an inclination to blame mental illness on moral weakness.

Views on restraint within mental hospitals were highly significantly related to the belief that incarceration was likely to prove permanent for most patients.

SECTION 7

SYMPATHY AND SOCIAL DISTANCE SCALES

I Sympathy Scale

Three hundred and seventy two[4] respondents were ranged in accordance with the scores allocated to their reactions to the eight statements, numbered 1, 2, 3, 4, 5, 7, 13 and 14. These were to be taken to indicate sympathy, and the scores were given as described in the preceding Chapter. The range of possible scores was/

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4. The total respondents were reduced by one from 373 on account of the failure of one person to provide any response to Statement 5.

was from 8 to 40 but the scores actually registered ranged from 19 to 40.

The scores are shown in full in Table 99 of the Appendix, condensed in Table 100 and represented graphically in Figure 6 overleaf.

It will be noted that the scores have an approximately normal distribution. Advantage was taken of this to divide the scores into three separate blocks or groups.

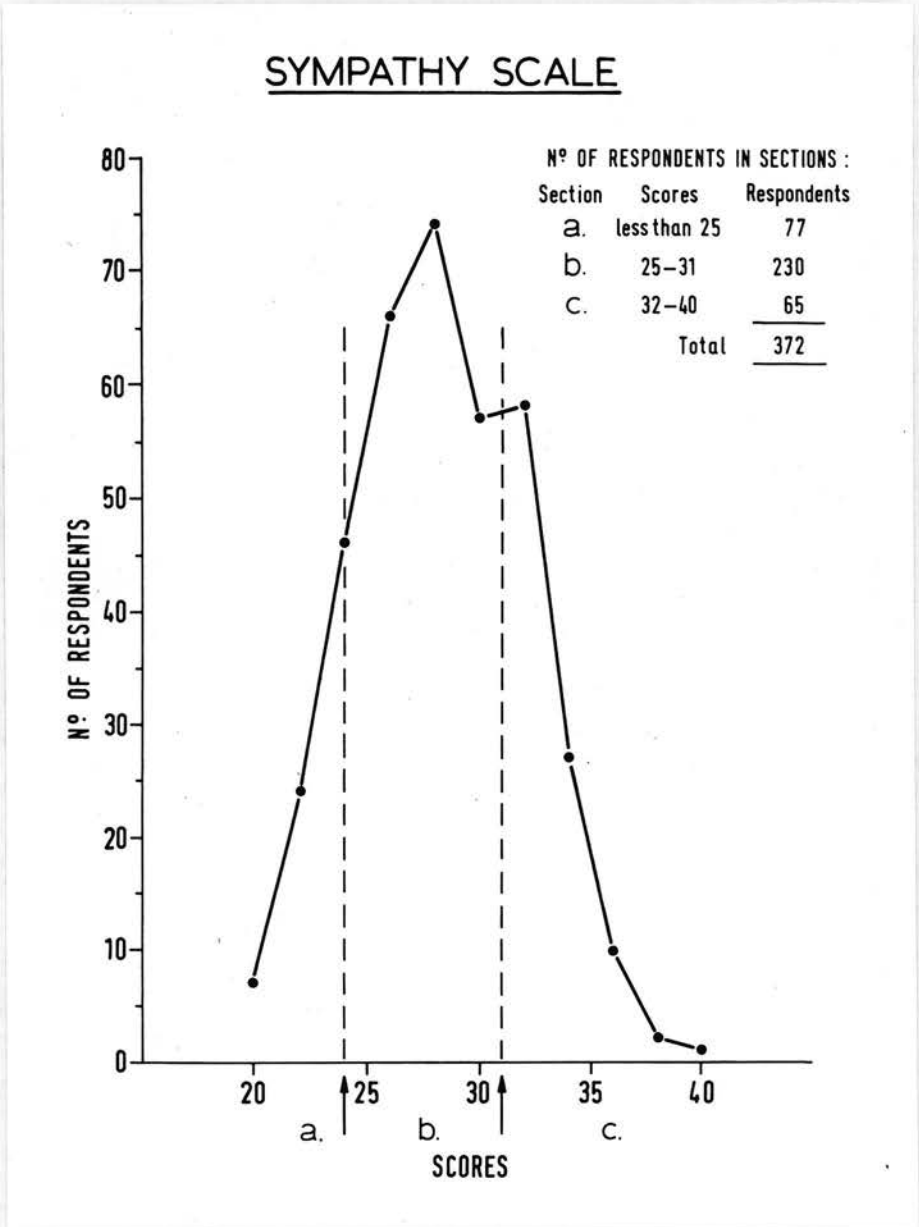
The first group, into which 77 respondents fell, was from Score 19 to Score 24 inclusive. The bulk of the respondents, 230 in all, occupied the central position on the scale, with scores ranging from 25 to 31. The third group of scores, from 32 to 40, were at the other end of the scale, these scores were received by 65 members of the sample.

The three sections of the scale were designated 'a', 'b' and 'c' for the purposes of the subsequent analysis, as shown in Table 101.

The reason for making the cut off points on these positions on the scale was in order to have a central portion respresenting the scores of approximately two thirds of the sample population, with approximately one sixth falling at either end of the scale, these representing scores roughly one standard deviation from the highest point of the distribution.

The three portions of the scale, 'a', 'b' and 'c', were used thereafter in considering the sympathy scores of various sub-groups of the sample population. Scores in the 'a' section resresented the/

FIGURE 6



Sympathy Scale.

the least sympathetic respondents and scores in the 'c' section the most sympathetic.

These three levels of sympathy scores were considered in relation to a large number of variables and the results are shown in Tables 102 - 117 of the Appendix (pages 365 to 371), which also indicate the results of the chi square tests of significance upon the figures.

The respondents did not in every instance total 372. This was on account of some failures to respond to particular questions and because of some respondents who were unclassified in respect of the variable in question. The total number of respondents is indicated for each separate table.

In the summary Table below (not included in the Appendix) the results of this section are brought together in a simplified manner, indicating those characteristics of the respondents which were related to increased sympathy for the mentally ill as measured by this scale.

Summary Table 3

The relationship between sympathy for the mentally ill and certain characteristics of the respondents

	Respondent Characteristic		Significance
Sympathy for Mentally Ill	Insanity rated as serious		n.s.
	Personal Experience of the mentally ill		n.s.
	Personal Visits to Mental Hospitals		n.s.
	Recently acquired Information on Mental Illness	(highly)	sig.
	Education beyond Primary level		sig.

Endorsement/

	Respondent Characteristic	Significance
Sympathy for Mentally Ill	Endorsement of Self Reliance (unsympathetic)	sig.
	Religious Denomination	n.s.
	Religious Observance	n.s.
	Sex	n.s.
	Age (Old unsympathetic)	sig.
	Social Class	n.s.
	Neuroticism Score	n.s.
	Extraversion Score	n.s.
	Child under 15 at home	n.s.

Sympathy for the mentally ill, as assessed on this scale, was not significantly related to a high ranking of the seriousness of 'insanity', nor to visits to mental hospitals. Personal experience of the mentally ill was almost but not quite significantly related to increased sympathy for them as a group. Recently acquired information on the subject of mental illness was, on the other hand, a highly significant factor in increased sympathy.

Increasing age, a low educational level and agreement with the 'ideal of self-reliance' were, conversely, all significantly associated with reduced sympathy.

Neither religious denominations nor religious observance, variations in the respondents' neuroticism or extraversion scores, sex, social class or the presence of a child in the respondent's household were found to be significantly related to sympathy scores.

Tables 118 and 119 in the Appendix were introduced to discover possible variation in the sympathy scores of respondents visited by different/

different interviewers. Two interviewers who had only completed very small numbers of calls were excluded and the scores grouped in a slightly different manner from the preceding tables. No significant variation was found.

SYMPATHY AND SOCIAL DISTANCE SCALES

II Social Distance Scale

The construction of the Social Distance Scale was along the same lines as the Sympathy Scale. The scoring of the items, Statements 6, 11, 15, 34, 37, 40 and 45, was described in the last Chapter. On this Scale the possible range of scores was from 14 - 70, the scores actually obtained ranging from 14 - 65.

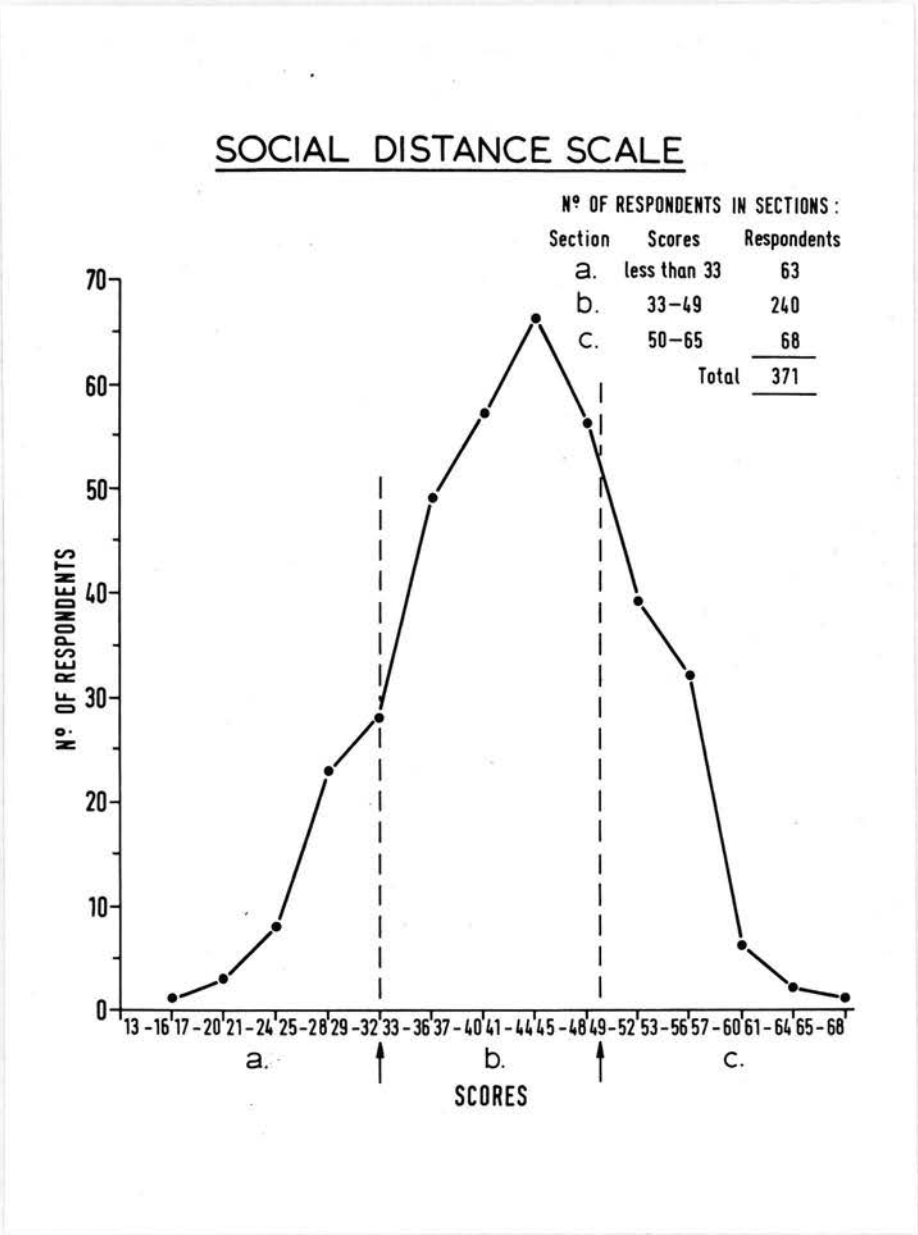
The compressed scores are shown in Table 120 and represented graphically in Figure 7 overleaf.

Three hundred and seventy one respondents were scored on the Social Distance Scale, the discrepancy between this number and the total for the entire sample being due to the fact that one person who failed to respond to Statement 15 and another who had "no opinion" on each of the seven items were excluded.

Like the Sympathy Scale, the scores on this Scale also approximated to a normal distribution. The cut off points were made at Score 32 and Score 49, dividing the scores into three groups, 'a', 'b' and 'c', in the same manner as was described for the Sympathy Scale.

This/

FIGURE 7



Social distance scale.

This is summarised in Table 121, which also indicates the direction of tolerance for ex-mental patients. Section 'a' scores were indicative of intolerance, Section 'b' scores were intermediate and Section 'c' scores indicated high tolerance.

Tables 122 - 137 indicate the comparisons made between respondents' scores on the Social Distance Scale and a number of different variables. As was the case with the Sympathy Scale, the number of respondents occasionally fell short of the possible total because of failures to reply or to be classified in the relevant categories. The total respondents is indicated for each table in the Appendix.

The situation is summarised in Table 4 below.

Relatively high tolerance for ex-mental patients in the community was significantly related to age under 50, to an education above primary level, to Social Class III and above (men), to a high score for neuroticism on the short form of the M.P.I. and to a low regard for 'self-reliance'.

None of the other variables, sex, experience, information, religion, extraversion or the ranking of 'insanity', bore a significant relationship to respondents' scores on this scale.

However, high scores for tolerance on the social distance scale were significantly related to scores for increased sympathy

Summary Table 4

The relationship between tolerance for ex-mental patients (as measured on the Social Distance Scale) and certain characteristics of the respondents

	Respondent Characteristics		Significance
Tolerance for Ex-mental Patients	Insanity rated as serious		n.s.
	Personal Experience of mentally ill		n.s.
	Visits to Mental Hospitals		n.s.
	Recent Information on Mental Illness		n.s.
	Education beyond primary level	(highly)	sig.
	Endorsement of Self Reliance (intolerant)		sig.
	Religious Denomination		n.s.
	Religious Observance		n.s.
	Sex		n.s.
	Age (Old intolerant)		sig.
	Social Class, Male		sig.
	Social Class, Female		n.s.
	High Neuroticism Score	(highly)	sig.
	Extraversion Score		n.s.
	High Sympathy Score		sig.

CHAPTER VIII

SOME IMPLICATIONS OF THE EDINBURGH FINDINGS

THE SAMPLE

Initially some apprehension had been felt regarding the Edinburgh population's possible response to requests for interviews on the topic of mental illness. But in the event the great majority of these contacted proved perfectly willing to co-operate in every respect and patently did not shun the subject. The success rate which was ultimately achieved compared reasonably with that of another Edinburgh survey on the less delicate question of smoking habits.

The sample was somewhat deficient in men under thirty and in women over sixty. However, since some of the more striking differences in opinions and attitudes proved subsequently to be related to age and since sex was not an important variable, the effect of these deficiencies may, to some extent, have cancelled one another out.

As had been the case with the members of the Greater London viewing public interviewed by Belson ten years earlier, familiarity with mental illness was high, although only fifty five per cent of the Edinburgh sample claimed previous personal knowledge of someone mentally ill as compared with almost three quarters of the London audience./

audience. Whilst this might suggest that the Edinburgh public are less well acquainted with the condition, it is more probable that the London group were simply subsuming a greater number of forms of disability under the heading of mental illness, since the interviews which Belson conducted had commenced with a fairly informal section on definitions. In Edinburgh, on the other hand, most respondents had placed the term "mental illness" in an intermediate position between insanity and nervous breakdown and it can possibly be assumed that the term was perceived thereafter in this rather more restricted context.

The fact that cancer clearly headed the small list of dreaded illnesses and took priority over psychiatric disturbances of any kind, including the emotive word "insanity", gives a glimpse of the current public rating of malignant disease. It is not possible to say, on the present evidence, whether "insanity" and "cancer" have actually changed places in the table of fear promoting diagnoses. The relative position of the psychiatric designations as compared with cancer does, however, indicate that the implications of mental illness are nowadays less personally alarming than the connotations of malignancy. And indeed this popular viewpoint is not unrealistically related to the differing possibilities of therapy.

A further indication of the frankness with which people approached the subject was the admission by six per cent that they themselves had once been mentally ill, although the circumstances of/

of the interview and the status of the interviewers precluded further probing on this kind of announcement and it was consequently not possible to discover anything of the illnesses concerned. But this sub-group at least felt no compunction about placing themselves into the category under consideration.

Over forty per cent recalled visits to mental hospitals and most had been there during the past ten years, when they should have been in a position to appreciate something of the modern therapeutic approach and the patients' physical surroundings. People were also recently informed upon the subject of mental illness at second hand, through the mass media. It had been hoped to ascertain something of the actual content of the communications concerned but time and the limitations of the enquiry did not allow this. But subsequent consideration of the responses of "better" informed respondents suggested that the mass media in Britain today may be enlightening rather than obscuring public opinion in this area.

This sample of Edinburgh people were not ardent church goers, only a quarter claiming that they were regular attenders. As questions of religious observance were introduced casually in the course of the general enquiry there would seem to be no particular reason why respondents should prevaricate in this regard.

EDINBURGH AND LONDON VIEWS ON MENTAL ILLNESS

Although the inadequacies of the sample are not denied, the results/

results of the enquiry will, for the sake of simplicity, be taken as representing something of the state of Edinburgh public opinion in this field. In the course of the next section of the discussion, therefore, the members of the sample will be referred to as "Edinburgh people" and a similar liberty will be taken in connection with Belson's London group.

The survey which was carried out on the London B.B.C. audience has, among all previous investigations into attitudes to mental illness, the most pertinence for the present study. Comparisons with a survey done elsewhere in Britain are likely to be of more interest to psychiatrists and health educators here than a consideration of the results of most American investigations deriving, as they do, from such a very different socio-medical setting. Even intra-national comparisons are fraught with difficulties, these are multiplied on the international scale, particularly in the field of those attitudes which are, to some extent, culturally determined. Moreover, the London survey was a comparatively recent one, reflecting opinions of ten years ago. This is a field where there is reason to think that change is fairly rapid and many of the earlier American surveys may be reflecting opinions that much further out of date. Finally, many of the statements proferred in Edinburgh were very similar to the content of the London enquiry so that fairly close correspondences can be explored.

Edinburgh/

Edinburgh public reaction to the forty seven opinion and attitude statements will first be reviewed and some suggestions put forward as to the significance of the various results. Groups of statements will generally be considered together as affording a more reliable picture than the responses to individual propositions. This will be followed by an examination of the differing views of psychiatrists and public, before proceeding to evaluate the results obtained by the use of the sympathy and social distance scales.

The potential danger of the mentally ill

Statements number 1, 12 and 41 all referred to the potentially dangerous characteristics of the mentally ill and to their association in the popular mind with violent and unpredictable behaviour.

Summary Table 5 below compares the responses of Edinburgh and London people to a set of rather similar propositions on the theme of violence. There was close agreement in the proportion of people, namely one third, who would see in the mentally ill a source of possible danger to the community.

The same suggestion was more gently hinted at in statements to do with unpredictability, emotionalism and the "need for careful handling". Such anxiety-provoking statements drew admissions from many more people to the effect that the mentally ill made them feel uneasy and insecure. Opinion in this area clearly still carries undertones/

undertones of fear and uncertainty.

Summary Table 5

Edinburgh and London views on potential dangers of mental illness

	Per Cent		
	Agree	No. op.	Disagree
Edinburgh sample, 1966			
"The mentally ill are dangerous" (No. 1)	33	16	51
"Mentally ill people are ruled more by their emotions than normal people are" (No. 12)	75	18	7
"The mentally ill are unreliable, you never know what they will do next" (No. 41)	57	21	22
London sample[1], 1956			
"You never know what they are planning and it may be harmful"	33	27	40
"To tell you the truth, they scare me a bit"	25	18	57
"They need very careful handling"	83	7	10

Views on hospital commital and its consequences

A series of statements all concerned with public awareness of the process of admission to hospital, retention in an institution and the possible outcome of such procedures are considered together in/

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[1] These were the views obtained after "The Hurt Mind" had been seen.

in Summary Table 6.

Summary Table 6

Hospital commital and its consequences

	Per Cent		
	Agree	No. op.	Disagree
"The mentally ill should be put away in institutions"(No. 2)	43	13	44
"As soon as someone begins to show signs of mental disturbance they should receive hospital treatment" (No. 7)	94	3	3
"Most people in mental hospitals nowadays have gone in of their own free will" (No. 43)	60	24	13
"Most patients in mental hospitals have to be kept there against their will" (No. 9)	35	18	47
"Few people who enter a mental hospital ever leave it" (No.32)	13	14	73
"Mental patients usually settle back into ordinary life again quite easily when they are discharged from hospital" (No. 29)	52	23	25
"Many of the mentally ill people who seem to be better will be back for more treatment later on" (No. 33)	56	25	19

There is an interesting contrast between the reactions to Statements 2 and 7. Whereas opinion was divided as to whether mentally ill people should be "put away", the vast majority appeared eager to recommend hospital treatment upon the first suggestion of mental/

mental disturbance. This could be taken as a popular triumph for the modern medical model of mental illness, but the very size of the majority in favour of hospitalisation raises the suspicion that it may be custodialism which is being recommended in the guise of care.

Whilst voluntary admission procedures are fairly generally known, as many as forty per cent of people are still in ignorance or mistaken regarding current policy. This is a proportion which education should surely aim to reduce, provided that psychiatrists can agree upon the desirability or efficacy of in-patient treatments.

Almost half the population realise that patients inside hospital are not subject to physical restraint to keep them there. This does, however, still leave over half the Edinburgh respondents either dubious on this score or believing in the continued necessity for restrictions.

Mental hospitals are evidently not now regarded, in Edinburgh at least, as final depositories for the deviant and most people are aware that patients have the prospect of release. But the total effect of a period of stay in a mental institution is none too favourably regarded. Only just over half the sample anticipate for patients an easy transition back to "ordinary life", and more than half take the realistic view that further spells in hospital are in prospect for someone who has once been inside.

This lends some support to the views of those sociologists (see Chapter I) who have pointed to the lasting consequences of labelling/

labelling someone as mentally ill. It is, they maintain, a label easy to apply but difficult to erase. It has by no means yet been established, however, whether the tendency for the mentally ill to have frequent encounters with therapy is because of or in spite of the prevailing attitudes of their society. And the fact that improvements in treatment are bound to influence and modify public attitudes makes the task of unravelling the individual effects of these two factors in a changing situation extremely difficult.

Explicit sympathy for the mentally ill

The two statements, Number 3, "People who are mentally ill are to be pitied" and number 14 "What the mentally ill need more than anything else is to have people show them sympathy", are both straightforward invitations to benevolence and it was not to be expected that many people would express outright disagreement. Most Edinburgh people were indeed outwardly sympathetic in these terms, and Belson found 89 per cent of the London viewers agreeing with the statement, "I feel sorry for the mentally ill" and 68 per cent saying, "I pity them".

However, some respondents in the pilot study specifically stated that, in their opinion, to show "pity" or "too much sympathy" might simply make the mentally ill still more sorry for themselves and so impede their recovery. This attitude of hearty reassurance, along "pull yourself together" lines, is probably fairly widespread and/

and may in fact have the effect of delaying recourse to medical advice. Until the connection between early consultation (at any level) and subsequent increased chances of "cure" can be established, such delaying or denying tactics could well be seen as an indication of welcome community tolerance for minor illness.

The contagion of mental illness

Statement 4 asserts, "Close association with people who are mentally ill is liable to make a normal person break down". Over forty per cent of people appear to feel some apprehension over this possibility. The fear is not an unreasonable one, since the constant strain of living with a disturbed individual can be very real and is a factor which has to be seriously weighed when advocating "community care", unless the community is prepared to provide sufficient support.

But agreement with this proposition may also be implying a degree of repugnancy regarding mental illness, as something which could directly damage and contaminate someone. The company of the mentally ill may be seen to have additional disadvantages, implicating an associate in the loss of social status accompanying a diagnosis of mental illness.

A taboo topic

Statement 5 suggested that "mental illness is something it is best/

best not to talk about". In this respect the contemporary Edinburgh public seem to be less inhibited than their London counterparts who tended to take refuge in the "no opinion" sector. The majority of Edinburgh people, ten years later, are quite ready to discuss the subject. Indeed the success of the entire survey is evidence of the ease with which the topic is contemplated today.

Social acceptability of the ex-mental patient

Statements referring to the social acceptability of an ex-mental hospital patient were employed in the construction of the Social Distance Scale. However, since the hypothetical situations posed for the respondents were very similar to those used in London, comparisons have been made in Summary Table 7. Once again, to simplify the tabulation, only the results which Belson noted after the B.B.C. television series are used, although in fact these were very close to his "before series" figures.

The Edinburgh people seemed less prepared to countenance distant relationships with ex-patients than did the Londoners. But as far as closer roles were concerned, as teacher, baby sitter or family member, there was little difference between the two groups of respondents.

Summary/

Summary Table 7

Social acceptability of ex-mental patients

Role suggested for ex-patient	Per Cent Replying: Edinburgh 1966 Agree	No op.	Dis-agree	London 1956 Yes	Not sure	No
Workmate	77	11	12	92	6	2
Next door neighbour	64	19	17	89	9	2
Important or responsible position	39	26	35	25	37	38
Baby sitter	26	26	48	20	36	44
Teacher	26	27	37	20	36	44
District Nurse (Ed.) Nursemaid (Lond.)	50	26	24	20	36	44
Family member through marriage	21	24	55	21	44	35

Perceived causes of mental illness

The statements relating to possible causes of mental illness have been ranged in Summary Table 8 according to the percentages of people who agreed with the suggestions put forward. The statements have been considerably abbreviated but can be consulted in their complete form in Appendix VI.

Summary/

Summary Table 8

Some popular opinions on the cause of mental illness, Edinburgh, 1966

Cause	Percentage agreeing
Job worries (No. 22)	89
Overwork (No. 23)	82
Stress and strain of present day living (No. 20)	80
Money worries (No. 26)	74
Neglect in childhood (No. 24)	70
Menopause (No. 44)	65
Unhappy home life (No. 19)	65
Lack of moral strength (No. 27)	42
Gloomy thoughts (No. 25)	39
Sexual overindulgence (No. 28)	38
Accidents or illness (No. 17)	37
Drink (No. 18)	30
Masturbation (No. 46)	15

People look outside to the particular circumstances in which their lives are lived, to explain the occurrence of mental illness, blaming "strains" which they perceive as existing in the external environment rather than within their own personalities. This sample was predominantly composed of members of Social Class III and below, with jobs which may indeed have been more precarious than/

than those of the professional classes and with perennial problems about finance. In the face of such circumstances many people recommend a determined attitude of enforced cheerfulness on the assumption that mood can be changed or directed at will. So the effect of a bad situation is not seen as leading inevitably to mental breakdown but to be, partially at least, within the power of the individual to control (see Recipes for Avoiding Mental illness, p.162).

Belson[2] also found 83 per cent of his sample blaming "strain" and "worry" of one kind or another. A much smaller proportion of the London group (48 per cent) than of the Edinburgh sample specifically indicated family troubles and only 33 per cent of Belson's sample made reference to surroundings in the past, such as ill treatment as a child. The Edinburgh respondents seemed to be placing much more emphasis on the effect upon children of feeling they are "not wanted", but whether this is evidence of the spread of Bowlby's (1953) gospel, or whether it simply reflects a long-standing local belief cannot be determined. The menopause ranks high on the Edinburgh list, whereas it was only referred to (along with puerperal disturbances) by 13 per cent of Londoners. But the remainder of the causes, such as a bad way of life (as evinced by drink and moral weakness), and specific physical causes like accidents or illness, came low among the baleful influences cited in both Edinburgh and London. It is noteworthy that although only

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[2] The method of presentation of questions in this area differed as between London and Edinburgh, Belson using an open form of enquiry requesting causes of mental illness. So the results may not be strictly comparable.

15 per cent of the Edinburgh sample think that masturbation can cause mental illness, nearly 40 per cent had no opinion about it and the same proportion regard "sexual overindulgence" as dangerous.

Both the popular tendency to blame symptoms on circumstances and the prevailing psychiatric inclination to excuse "bad" behaviour on grounds of background or personality is deplored by some practising clinicians. Forrest (1967) has lately posed the question, "Can we afford mental health?" and has proposed a return to a greatly restricted sphere of therapeutic concern. Such a panic retreat on the part of psychiatrists would seem particularly unfortunate at a time when their part in the system of medical care is being increasingly accepted by the public.

Ideas of mental illness as divine punishment or as meriting severe restraint may now have gone.[3] Although the popular view today is still an over-simplification and in need of further modification, future changes should be in the direction of greater mutual understanding and acceptance between the psychiatrists and their clients.

The popular view as expressed in this survey finds further support from the observations of many psychiatrists regarding the importance of social factors in illness. Even if the prior personality make up of people subjected to particular environmental pressures/

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3 This was not specifically established by the Edinburgh enquiry.

pressures may determine their liability to breakdown, the social circumstances cannot for that reason be disregarded in a multi-factorial situation.

Some remaining opinion and attitude statements

Self reliance

The statement (No. 47) used as a measure of peoples' emphasis on the importance of self reliance (after Phillips, 1965) proved to be a suggestion bringing out definite attitudes. Sixty per cent endorsed the sentiment and only six per cent had no opinion on it. It would be desirable, however, to expand the exploration of this factor with further research.

Perceived public tolerance

Statement 42, "People nowadays are sufficiently tolerant towards the mentally ill" evoked what appeared to be a certain complacency regarding the current situation. Perhaps the sixty per cent who agreed had in mind the contrast between the present climate of opinion and what obtained in earlier times.

Personal dread of mental illness

The statement (No. 31) expressing horror at the idea of developing a mental illness was supported by over seventy per cent of people. The response tended to corroborate the feelings about psychiatric disability expressed in the rank ordering of diagnoses at/

at the introduction to the schedule.

Personal characteristics of the mentally ill

These are touched upon in Statements 8, 10, 35, 36, 38 and 39. Seventy-one per cent of the Edinburgh group agreed that the mentally ill "seem to live in a different world", but the majority would not go the length of classifying them as scarcely human. Most people have no views on the matter of patients' "glassy eyes", which no doubt represents a sensible reaction to a somewhat stupid statement. Opinion divides fairly evenly on a statement of their supposed strangeness ("When a person becomes mentally ill it's just like losing them altogether") and on their personal untidiness, but the belief that mentally ill people are likely to manifest suicidal behaviour is held by sixty per cent of the sample. The latter response may be taken as further evidence of the continuing tendency to connect mental illness and violent behaviour.

Variables affecting responses to certain attitude and opinion statements

Detailed in Chapter VII, Section 6, these aspects of the analysis tended to bear out the findings of most American investigators to the effect that age and education influence opinions in this field, those who are old and ill-taught being furthest from "enlightenment" in whatever terms it happens to be measured. There was, moreover, a close relationship between age and educational level.

Recent/

Recent information was, however, having rather less effect than might have been hoped upon Edinburgh respondents' knowledge about mental hospitals. The relationship between information and knowledge of the manner of patients' voluntary admission was not quite statistically significant, nor did exposure to recent information significantly affect peoples' views upon conditions of custody within mental hospitals. In these respects the mass media would seem to be perpetuating, possibly in the interest of sensationalism,[4] a picture of outdated circumstances which all the best regulated institutions would wish to erase. There is no doubt, on the other hand, that conditions in many mental hospitals in Britain still leave much to be desired and that the public is justifiably shocked and apprehensive about them.

Experience counts for more than second hand information in the matter of current admission procedures. But respondents who have known a mentally ill person are just as likely to regard them as unreliable and unpredictable as are the rest of the population. However, this finding is probably not so much discouraging as realistic, pointing to the need which friends and relatives feel for some kind of professional support in their trying circumstances. There is no value in pretending that caring for someone with mental illness is equivalent to looking after a person whose leg is in plaster, and the continuing uncertainty and anxiety felt by relatives and/

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[4] See Scheff (1966) on the mass media in the U.S.A.

and others in coping with psychiatric disability deserve recognised outlets and means of relief.

An interview schedule of this nature, applied to a random sample of the general population by interviewers not specifically trained in psychiatry or psychology, cannot explore the particular circumstances which must underlie the answers to simple questions.[5] The value of individual replies is necessarily diminished and quality suffers at the expense of quantity. It would, for instance, have been interesting to know more about the respondents' attested "experience" of the mentally ill in order to explore the kind of past situations which had contributed to their current views. But the large mesh of a public opinion survey cannot hope to net the minutiae of personal experience. Such information is better obtained by an entirely different approach.

The finding that nearly sixty per cent of the Edinburgh sample came out in favour of sturdy self reliance was somewhat unexpected. On the basis of responses to one statement, there would seem to be some kind of "norm of self reliance" in parts of Scotland as well as in parts of the States. Here it is found, not surprisingly, to be associated with specific condemnation of overt mental illness as evidence of personal moral weakness. Although it was not investigated in this study,[6] "help seeking" for psychiatric problems may/

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[5] It should also be appreciated that the number and extent of questions was limited not only by concern for practical applicability but also by the intention of selecting those questions most likely to uncover differences between groups in the population.

[6] The attempt to do this was relinquished after the first pilot study had indicated that it would be unduly tedious and time consuming.

may be deprecated by most Edinburgh people.

The influence of sex upon responses was only explored in respect of a few specific statements and the results are not very important, although possibly granting to women a rather more liberal attitude towards the entire topic of mental illness and less anxiety regarding the supposed influence of sexual practices upon its development.

Recipes for avoiding mental illness

A sample of respondents' replies to a request for popular prophylaxis serves to supplement the opinions which the rest of the interview schedule uncovered. There is the same simple faith in the importance of avoiding stress and worry, as part of a philosophy which advocates perpetual optimism and which, confusing cause and effect, cheerfully disregards the aspects of personality which might render happiness impossible. There are, however, exceptions to the prevailing sentimentalism, as witness number 19, the Polish woman who offered her thoughtful reflections on a family's reactions to misfortune. And many people emphasised the importance of good personal relations and a satisfactory adaptation to one's own life circumstances. It is probably unfair to ascribe over much importance to single statements, proffered on the spur of the moment without the respondents having much opportunity to enlarge upon their views or to develop them under the stimulus of further questioning. But the spontaneous "recipes" do bear out the results obtained by the use of set statements.

Popular/

Popular and medical models of psychiatric disturbance

In the last chapter a close comparison was made between the views of a group of Scottish psychiatric specialists and the lay public. This section of the enquiry was unduly simplified by the reduction of statements to those which the pilot study had indicated would uncover the maximum differences.

The psychiatrists as a group discounted the role of physical causes in producing mental illness; taking a more sophisticated view of causation, they denied the possibility of avoiding illness by avoiding work and "worry" or by simply resting; they discredited the prophylactic virtue of vacations as much as they denied the baleful effects of sex. Feeling strongly about the role of upbringing in the genesis of mental illness, they disdained to view the condition as irremediable and were perfectly well aware of the frequency of discharge from hospital of the patients under their care. Most of the psychiatrists especially disliked glib generalisations about the direct effects of "strain" and "worries". But they were prepared to recognise the long term problems which psychiatric illness presents, with its concomitants of difficult adjustments to life outside hospital and the possibility of frequent bouts of ill-health.

The views of the public have already been largely dealt with in this chapter. They are even more pessimistic than the experts regarding the possibility of final cure for a condition which, on the/

the whole, they tend to dread more.

Measures of sympathy and social distance

The responses to the groups of statements used to constitute the sympathy and social distance scales respectively, proved to be closely related. People receiving high scores for "sympathy" were also more inclined to contemplate ex-mental patients in close social proximity.

The two scales which were constructed were thus measuring different aspects of a generally benevolent and enlightened approach to mental patients and their problems. The use of these scales was an extension of the analysis of replies to specific questions and the scales were intended to counteract the ambiguity which can attend the interpretation of isolated answers.

As has been described, eight statements were combined to constitute what was called a Sympathy Scale. Some of these statements were explicit expressions of concern, mentioning "pity" and "sympathy", whilst others touched more obliquely on the subject and were phrased to provoke responses which might indicate either suspicion or rejection.

The key themes of the individual statements, in order, were:

(1) potential danger
(2) need for close custody
(3) pity
(4) possible contagion
(5) taboo topic
(7) /

(7) need for hospital care
(13) wisdom of segregation
(14) sympathy

However, the statements were not all unambiguous and agreement with them could be open to differing interpretations.

In order to validate the scale and to determine whether it actually measures "sympathy" for the mentally ill, it would require to be used upon a group of people whose feelings in this respect were not in any doubt. Such a group is, however, by no means easy to discover to even to define.

Much of what has already been written earlier in this study has described the demonstration of considerable differences in attitudes to the mentally ill, differences which are not simply the result of the variations in experience or training or point of view of separate groups in the community, but which have been further confounded by differences in the aims and methods of separate investigators.

The term "mental illness" itself evokes different concepts in the minds of people according to their previous familiarity with the term and the connotations, personal or theoretical, which it has acquired for them. It might seem at first as though the sympathy of relatives could be relied upon. But such sympathy is likely to vary with the nature and quality of the relationship prior to the illness, the circumstances of the illness as it affects a whole family, and the nature of the symptomatology. It is, for example, recognised even/

even at law that prolonged psychiatric illness of one partner to a marriage can give grounds for divorce. And, at a much earlier stage in a mental disorder, a patient's behaviour may well provoke more exasperation than understanding.

Nor is the problem solved by going within a mental hospital in the search for sympathy. Many studies have revealed strong elements of authoritarianism and custodialism among hospital staff and sympathy is all too often at a discount.

To select people with strong religious views would not provide a reliable solution either. Unless such people were also imbued with some conception of the current psychiatric views which, in effect, maintain that "Tout comprendre, c'est tout pardonner", they might well continue to condemn certain sectors of behaviour which are currently termed illness by psychiatrists. This would constitute another example of the persistent semantic and linguistic difficulties in this area since, particularly in the fields of sexual deviation and violence, illness could not be taken to include for different people the same range of behaviour.

One way out of the enigma is the purely pragmatic one which was in fact adopted in this survey, namely, to present the same set of statements to all kinds of people and then to contemplate how they scored in relation to one another. No claims are posed for the absolute value or meaning of the resulting so-called "scale" which merely supplies one way, out of all the possible ones, of sorting people. It must be clearly understood that respondents are/

are simply being sorted in terms of their combined responses to certain specific statements. The term "sympathy", as used in connection with results, is no more than a convenient shorthand, and the precise meaning given to the other term, "Mental illness", by individual respondents must remain a matter for speculation.

This deficiency in definition is partly inherent in the nature of public opinion polls. Whilst exhaustive questioning in depth could doubtless reveal much more of the constituents of each person's experience in this field and could begin to point to the elements which have combined to form his special view of mental illness, such an approach is not feasible with limited resources. The resources in question are not merely time, money and staff, but include the patience of respondents which is no more inexhaustible than the other pre-requisites.

Even if such information were obtained from a large number of people it would forthwith present a very formidable problem in analysis and would not necessarily circumvent the particular difficulties with which the endeavour was originally faced, since the analysis would involve the use of experiential criteria for judgement, themselves based upon pre-existing ideas and ideals of sympathy, tolerance and the like.

Although these difficulties may seem more acute when the mechanism of a scale measurement is introduced it is, of course, not essentially different from the possible confusions which can underlie the use of individual statements and the recording of replies in terms/

terms of percentages agreeing, strongly agreeing and so on. It can be argued that the use of a set of statements rather than one or two will actually reduce the error involved, allowing for possible differences in the interpretation of several questions or statements to become more apparent to the investigator.

The present study has endeavoured to have the best, or the worst, of both world by considering responses to individual statements as well as the overall sentiments hinted at in the combination of certain scores.

It might be said that an alternative approach would have been to use the Thurstone (1930) method of submitting statements to judges who would range them into a series with equal appearing intervals. But since opinion is divided as to the part which such judges' own views may hold, and since one would still be without a prior means of judging the judges' sympathy, the problem of validity would not have been avoided.

In the use of the Social Distance Scale, based upon one used originally by Bogardus (1925) to distinguish attitudes to certain racial groups, rather firmer ground is reached. Respondents are presented with fairly tangible possible situations which might confront them in real life. It is still impossible to avoid confusion about what the "ex-mental patient" is meaning to each of them but, aside from that, the set of theoretical social relationships is simple and has practical importance[7].

The/

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[7] It is fully realised, however, that the present exercise suffers from the weakness inherent in almost all attitude studies, namely the difficulty of relating peoples' statements of intention to their/

their actual behaviour in practice. The current protests of local home owners in an Edinburgh suburb at a proposal to establish an adolescent psychiatric unit in a building outwith the hospital grounds suggest that sympathy and tolerance may be strained by events. Unfortunately there was no opportunity for prior testing of the attitudes of these eventual protesters.

The scores were weighted in this case, as the person prepared to have an ex-mental patient in the family deserved a higher score from someone only consenting to work with them. This did involve also alloting higher scores for disagreement with some suggestions than with others but, since it is less surprising or deplorable that someone should hesitate over marriage to an "outsider" than that they should decline casual contact, the lowest scores would seem to be appropriately awarded to those evincing the most social ostracism.

Determinants of Sympathy

Bearing in mind the reservations which have been expressed regarding the Sympathy Scale and its limitations, it is possible to make some observations on the varying sympathy levels of different sections of the sample. Although sympathy, as measured on this scale, increased with experience, the difference between those with and without personal experience was not quite significant at the five per cent level, bearing out what has been suggested regarding the possible effects of particular individual circumstances which the schedule was not sensitive enough to reveal.

It is of particular interest to discover the apparent influence of/

of recent information, acquired mainly through the mass media, in increasing respondents' sympathy towards the mentally ill. It may be the case that the instruments of mass education in Britain are successfully conveying a picture of psychiatric illness which excites regard rather than rejection and which stimulates humane impulses in relation to this sort of misfortune. If the components of the scale are recalled, this would suggest that the mass media in this country are underplaying the dangerous and contagious features of mental illness. They may be replacing a concern for custody, for society's benefit, with the concept of care, for the benefit of the individual. The fact that the subject is being broadcast at all, disposes logically of its present unsuitability as a topic for news, documentary or drama[8].

Both Nunally and Scheff have laid a great deal of stress upon the distorting picture of mental illness which they maintain is being disseminated by the mass media in the United States. Nunally who, it will be recalled, undertook an extensive content analysis of the media, came to the depressing conclusion that the picture of psychiatric disturbance which they promoted was even further from that of the experts than were the opinions of the general public. Scheff, although he did no specific research to support his contentions, has insisted in several recent publications, that the popular/

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8 Recently the topic of cancer has begun to receive very frank treatment in television documentaries in this country.

popular press and television in America take every opportunity of associating violent, irrational and sub-human behaviour with the popular stereotype of madness.

No claim is made here to assess the actual content of the organs of mass information in Britain upon this topic. The evidence provided is no more than suggestive and the highly significant relationship between information and sympathy could indeed be open to other interpretations. It is, for example, possible that those who are already well-disposed towards the mentally ill, who take a certain interest in psychiatry or psychology, or who have particular personal reasons for special concern may all be more inclined to pay attention to information items upon this subject. Lack of interest or a positive distaste for the topic in all its guises could, on the other hand, prompt people to "switch off" or "turn over" whenever they were about to be assailed by the distasteful subject.

However, Nunnally was also of the opinion that age and education did not influence attitudes in this field. In so far as this scale does constitute a measure of attitude rather than opinion (and the distinction is admittedly a fine one), there does seem to be a definite relationship existing here between a sympathetic attitude and information. The Edinburgh survey also seems to reveal a relationship between sympathy and age and education.

Regarding the relationship between sympathy and age, whereby those over fifty score significantly lower on sympathy, the survey cannot determine whether the over fifties now revealed as being relatively/

relatively unsympathetic have always been so or whether their sympathetic tendencies have decreased with increasing age. Unfortunately, opinion/attitude studies in this field are still at an elementary stage of development and the refinements of cohort studies are untried. It would not, however, seem inherently unreasonable to assume that the views of the older members of the community were crystallised some decades ago when the possible and actual treatment of the mentally ill was very different from what it is today. Further evidence for this comes from the association of advanced age with the tendency to treat as taboo a topic which is now being very widely aired. In other words, it is more likely that the limited sympathy of the aged for the mentally ill is a function of information and education in the widest sense rather than an inevitable concomitant of decrepitude. If this is the case the acceptance of mental hospitals and psychiatric diagnoses would seem likely to increase. [9]

The importance which people place upon self-reliance turns out to have some of the same consequences in Edinburgh as in Dartmouth, U.S.A. The degrees of rejection or lack of sympathy related to differing sorts of help-seeking were not explored, but the mentally ill were clearly denoted in the statements with a label which gave at least some indication of the severity of their state. Too much stress/

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9 Posing problems of economy and psychiatric man power beyond the concern of this study.

stress should not be laid upon this finding, depending as it does upon responses to a single statement of "self-reliance", but the association is probably more closely expressive of an attitude than are the associations involving age and education where informed opinion is undoubtedly closely involved.

Although religion might have been expected to increase sympathy there are, as has been said, reasons for rejecting this expectation as an over-simplification and in fact it was not found to be a significant factor. Somewhat surprisingly, sympathy proved class-less and unrelated to sex. But just as mental illness is no respecter of either sex or status so the accommodation to it must be a matter for everyone.

Social acceptability of ex-patients

Respondents' readiness to tolerate ex-mental patients in the community resembled, in a number of respects, their sympathy for the mentally ill. Age under fifty, an education above primary level and a low regard for self-reliance were all associated with increased tolerance as measured on the Social Distance Scale. In addition, however, the male respondent's social class was involved, those of Class III and above being significantly more tolerant. It is tempting to speculate upon this finding and to wonder to what extent the image of mental illness held by the lower social classes could be affected by the schizophrenics who predominate in lower status occupations and social settings. Could the increased readiness of higher/

higher classes to accept the ex-patient relate to a different picture of the type of person whom they imagine in the various roles? The survey, however, does not purport to answer this question.

Rawnsley and his colleagues have been exploring the possible association between the presence of neurotic symptoms in someone and their readiness to accept similar symptomatology in others. Using the very limited short M.P.I. instrument, it was the case among the Edinburgh respondents that an increased neuroticism score was highly significantly associated with a greater willingness to mix with ex-mental patients. Perhaps people with a tendency to neuroticism can perceive some connection between their own anxieties and the social difficulties which beset a patient who has once had treatment for mental trouble. But high N. scores on the M.P.I. were not significantly related to increased scores for sympathy, only to higher scores on the social distance scale. Recalling the components of that scale, with its references to the possible menace and contagion of mental illness and the advisability of segregation for its victims, it may be that such statements would arouse anxiety in people who were already inclined to be neurotic. Their sympathy score would not then be high. But the ex-mental patient, on the other hand, might suggest someone now relieved by treatment of their former dangerous propensities and deserving of toleration. This is not a very satisfactory explanation, since it is unlikely that neurotics alone should avoid the labelling procedure adopted by many people towards individuals who have once been psychiatrically ill.

Another/

Another explanation might be that people who, although they are unstable and have neurotic tendencies, are nevertheless compensating well and are not seriously incapacitated, feel out of sympathy with those who appear to have "gone under" when affected by nervous symptoms. However, this would imply an association in the mind of the high N. scorer between his own difficulties and feelings and those of the mentally ill.

The proportion of people in this survey with scores for neuroticism in the upper ranges was itself surprisingly high. The association of personality features with sympathy and tolerance for the mentally ill deserves to be followed up by more careful investigation. This survey has only been able to raise questions in the area, which cannot be resolved without controlled experiments, involving, for example, the use of these scales upon known neurotic patients.

CONCLUSIONS

The Edinburgh 1966 survey upon a random section of the adult population has provided, on the whole, an encouraging picture of the level of local opinions and attitudes in the field of mental illness. Whilst many traces of old stereotypes do remain and whilst the public has not by any means yet completely adopted the prevailing psychiatric view, the subject is approached with frankness and freely discussed. The relationship between people's views and their age and/

and level of general information would suggest that further improvement in the direction of sympathetic and enlightened attitudes may be anticipated. It is important that if the education of the public through the mass media is to continue that it should, if possible, concentrate upon those aspects of the topic where there is the most remaining uncertainty. The implications for the psychiatric services of future further increases in public tolerance and acceptance of mental illness and mental patients is a question which this survey is bound to pose.

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ACKNOWLEDGEMENTS

This study was carried out with the aid of a scholarship from the Medical Research Council.

Professor G.M. Carstairs and Dr. Graham Foulds, who supervised the survey throughout, have given their support and encouragement to an investigation in which both of them, in different ways, have had a special interest. Their very practical advice and critical judgement have been invaluable.

Thanks are also due to those Scottish teachers of psychiatry who completed questionnaires and to Professor Rawnsley of Cardiff for preliminary suggestions when the study was first envisaged.

Mr. Walter Lutz, Dr. Keith Hope and Mr. Stanley Sklaroff have assisted in the matter of sampling and with the statistical analysis. At another, earlier stage, Mr. John Nimmo and Mrs. Marion Nimmo helped with the preparation and preliminary sorting of punch cards and Dr. R. Kapur co-operated in coding.

From Dr. Sidney Chave and Mr. Mark Abrahams came suggestions on interviewer training, whilst Mr. William Belson and Mr. J.D. Halloran were consulted regarding the assessment of the mass medias' influence. The assistance of all these individual advisers has been much appreciated.

Miss Sandra Taylor has been responsible for the typing, and the Medical Photography Department has meticulously reproduced and mounted the illustrations.

The/

The competence of the interviewers and the co-operation of the general public made the field work in Edinburgh possible.

Finally, I would like to thank my family for their forbearance throughout the whole lengthy process of data collection and analysis.

APPENDIX I

FIRST DRAFT QUESTIONNAIRE

HEALTH OPINION SURVEY

Sections I - X

and

Summary of First Draft Questionnaire

APPENDIX I

FIRST DRAFT QUESTIONNAIRE

HEALTH OPINION SURVEY

QUESTIONNAIRE SURVEY NUMBER:

INTRODUCTION

I believe that you have already had a letter from us describing a survey that is being made in Edinburgh. Nowadays many doctors and welfare workers are beginning to realise how important it is to get the point of view of ordinary people on various health matters. We think it is very valuable to get your own personal viewpoint and experience and opinions. Your ideas and the ideas of other people like you should be taken into consideration when health policy is being decided.

Anything that you say will be treated as strictly confidential and you will remain anonymous. We are very grateful to you for agreeing to help in this study .....

SECTION I

PERSONAL DATA

1. AGE GROUP IN YEARS: 20-29 = 1; 30-39 = 2; 40-49 = 3; 50-59 = 4; 60-69 = 5; 70-79 = 6; 80+ = 7.

2. SEX: Male = 1; Female = 2.

3. MARITAL STATE: Single = 1; Married = 2; Widowed = 3; Separated = 4; Divorced = 5; Divorced and Remarried = 6; Widowed and remarried = 7.

4. EDUCATION: No education = 1; Primary education = 2; Secondary education; Secondary modern = 3; Senior secondary = 4; Advanced education = 5.

5. PLACE OF BIRTH: Scotland = 1; Elsewhere in U.K. = 2; Commonwealth = 3; Europe = 4; U.S.A. = 5.

6./

6. LENGTH OF RESIDENCE IN EDINBURGH: 1 yr. = 1; 1-4 yrs. = 2; 5-10 yrs. = 3; 10-20 yrs. = 4; 20+ = 5.

7. Householder = 1; (or dependent relative of householder). Tenant = 2; Lodger = 3.

8. ANNUAL INCOME OF RESPONDENT OR MAIN FAMILY WAGE EARNER: £500 = 1; £500-£1,000 = 2; £1,000-£1,500 = 3; £1,500-£2,000 = 4; £2,000+ = 5; No answer = 6.

9. RESPONDENT'S OCCUPATION (as stated)

(If retired write "R" plus classification of previous main occupation. If "housewife", classify by husband's occupation).

Classification:
1 = Class I Professional
2 = Class II Intermediate
3 = Class III Skilled occupations
4 = Class IV Partly unskilled occupations
5 = Class V Unskilled occupations
6 = Student
7 = Unemployed

10. OCCUPATION (MAIN) OF RESPONDENT'S FATHER: (as stated)

Classify as i = 1; ii = 2; iii = 3; iv = 4; v = 5.

11. NATIONALITY: Scottish = 1; English = 2; Irish = 3; Welsh = 4; Commonwealth (specify) = 5; European = 5; American = 7; Other = 8.

12. RELIGION: None = 1; Catholic = 2; Presbyterian = 3; C. of E. = 4; Non-conformist = 5; Other = 6.

13. FREQUENCY OF RELIGIOUS OBSERVANCE: Never = 1; For Family Ceremonies = 2; For Religious Festivals = 3; Monthly = 4; Weekly = 5.

SECTION II

RESPONDENT'S PERSONAL EXPERIENCE OF MENTALLY ILL PERSONS

Now that we have got these details sorted out I should like to ask you a few questions about your own experience of certain unwell people.

14./

14. Have you yourself ever known anyone who had a nervous breakdown? Yes = 1; No = 2.

15. (If yes) How many different people? 1. 2. 3. 4. 5. 5+.

16. Were they (was he or she) friends of yours or acquaintances or relatives?

Parent M or F	= 1 2	other near relative	= 8
sib M or F	= 3 4	friend	= 9
spouse	= 5	acquaintance	= 0
child M or F	= 6 7	stranger	= X
		self	= Y

Relationship

Index Case	Parent M/F	Sib M/F	Spouse	Child M/F	Other rel.	Fr.	Acq.	Str.	Self
1									
2									
3									
4									
5									
5+									

17. How did you know they had a nervous breakdown?

If "doctor said so" or "I was told" or similar reply indicating definition by another, ask:-

18./

18. What did you notice about their behaviour?

Probe - Anything else?

Can you remember how they talked or dressed?

Answers given to be classified, for each index person cited, according to:-

	Case					
	1	2	3	4	5	5+
Motor phenomenon (e.g. over and underactivity, ties, rituals)						
Mood disturbance (e.g. incongruous, unduly labile, depressed, manic)						
Speech disturbance						
Thought disturbance						
Obsessional behaviour						
Delusions or hallucinations						
Perceptual disturbances						
Memory disturbances						
Sleep disturbances						
Sexual activity disturbed						
Violence						
Unpredictable behaviour						
Suicidal threats						
Paranoid features						
Eccentric personal appearance						
Other						

19./

Index person

19. 1 2 3 4 5 5+

Was this person (these persons)

admitted to a general hospital = 1
to an asylum = 2
to a mental hospital = 3
to a nursing home of clinic = 4

20. If yes, What was the name of the hospital (or institution)

Name of Hospital

Index person
1
2
3
4
5
5+

21. If yes to Question 19, Have you yourself ever visited a mental hospital? Yes = 1; No = 2.

22. If yes, I wonder if you found it as you expected it to be? Yes = 1; No = 2; No opinion = 3.

23. If no, What did you expect it to be like?

24. So what was the main thing about (name place) which came as a surprise to you?

25. What did you dislike about it?

(Classify subsequently by:- size of building; physical surroundings; type of ward accommodation e.g. open; closed; bedded or not; appearance of patients; activities of patients; behaviour of staff; treatment).

IF/

IF RESPONDENT HAS KNOWN NO ONE (see Q.14) WITH A "NERVOUS BREAKDOWN", ASK -

26. Have you ever known anyone who has been a patient in a mental hospital? Yes = 1; No = 2.

THEN PROCEED WITH QUESTIONS 15, 16, 18, 20, 21, 22, 23, 24, 25 FOR IDENTIFYING DATA, RESPONDENT'S MEMORIES OF PERSON(S) and RESPONDENT'S PERSONAL ACQUAINTANCE WITH MENTAL HOSPITALS.

27. Have you ever known any person who you would call "insane"? Yes = 1; No = 2.

If yes, get identifying data, description of remembered behaviour by repeating Questions 15, 16, 17, 18, 19, 20.

then ask -

28. What became of him (her)?

Now, I suppose all these cases were fairly serious but, on the other hand, there are some odd people about who aren't getting any kind of treatment.

29. I wonder if you can think of or remember anyone who you would have said was a bit queer or odd in some way? Yes = 1; No = 2.

If no, probe -

I mean someone whose behaviour you would call unusual?

Probe, try to remember way back to your childhood.

Regarding such a person ask,

30./

30. How would you describe them to me?

How else did they behave?

31. What was it, in particular, about them that made you think they were odd?

32. What about other people who knew them, did they think this person was odd? Yes = 1; No = 2; Don't Know = 3.

33. What sort of age were they? Child = 1; Adult = 2; Old Person = 3.

34. Sex? Male = 1; Female = 2.

35. And how old were you then?
0-19 = 1; 20-39 = 2; 40-69 = 3; 70+ = 4.

36. Where did this take place?
Birthplace = 1; Edinburgh = 2; Elsewhere = 3.

37. Were they:-

a mere acquaintance	= 1	a stranger	= 4
a neighbour	= 2	a relative	= 5
a friend	= 3	other	= 6

38. How did you feel about having them around? Did you think that anything should be done for them? Yes = 1; No = 2.

That nothing was necessary? Yes = 3; No = 4;
That they should be having treatment? Yes = 5; No = 6;
That they should not be about in public? Yes = 7; No = 8;
That they might be dangerous? Yes = 9; No = 10;
That they should be in an institution? Yes = 0; No = X;
Other = 13 (specify)

(If/

(If respondent quotes several people in this "queer" category, deal with each separately according to the headings of Questions 28-38 inclusive).

SECTION III

RESPONDENTS SOURCES OF KNOWLEDGE AND INFORMATION ABOUT MENTAL ILLNESS, NERVOUS BREAKDOWNS, INSANITY AND MENTALLY ILL PEOPLE

Now, whether you have had any first hand experience of this kind of person we've been talking about or not, I expect you've picked up some information on the subject in one way or another.

39. What would you say has influenced your own ideas about mental and nervous troubles and people who are mentally ill or insane or have had nervous breakdowns?

Newspapers and magazines?	Yes	No	Don't Know
books?	Yes	No	Don't Know
T.V.?	Yes	No	Don't Know
radio?	Yes	No	Don't Know
films?	Yes	No	Don't Know
talks or lectures?	Yes	No	Don't Know
conversations with other people?	Yes	No	Don't Know
other (specify).			

40. Did any particular show (book, programme, film) make a special impression on you? Yes = 1; No = 2; Don't Know = 3.

41. If yes, what was the show (book etc.).

SECTION IV

ATTITUDES AND OPINIONS OF RESPONDENT REGARDING MENTAL PATIENTS AND THE CAUSE AND CURE OF MENTAL ILLNESS

I am going to ask you now to consider this pack of cards. On each one of them there is a statement which has been made about the kind of thing and the sort of situation we've just been discussing. I expect you'll find that you agree with some of these statements and disagree with others. There aren't any right or wrong reactions to these cards. I'm simply going to hand/

hand you the cards one by one and when you've read what is written on a card I want you to "post" it into one of these boxes.

As you can see there are five different post boxes here. Supposing you agreed very strongly with what was written down, then you'd put the card in here (indicating "strongly agree" box). If you strongly disagreed, on the other hand, you'd put it in here (indicating appropriate box). And if you agreed or disagreed, but not very strongly, you'd use one of these (indicating boxes). And if you didn't have any special feelings one way or the other, then you'd just post it in this centre box.

Let me give you an example (hand respondent sample card inscribed:-

The Summers in Edinburgh are Always Very Hot

Just put it into the box which shows your own opinion best. Do you agree or disagree? How strongly?

I AGREE STRONGLY	I AGREE	NO OPINION	I DISAGREE

I STRONGLY DISAGREE

Alright, now here is the first of the other cards. I want you to go through them quite quickly, please.

(Hand the respondent set A of white cards).

42. SET OF 90 ATTITUDE AND OPINION STATEMENTS ON INDIVIDUAL CARDS, SUBMITTED IN THIS ORDER: (after Nunally, Belson, Star and others).

1. Sometimes it's difficult to think of the mentally ill as ordinary human beings. (B)
2. Most mental troubles in adults are due to things which happened to them when they were children. (N.7)
3. Physical rest wont prevent a mental disorder. (N)
4. The mentally ill should be kept in hospitals.

5./

5. X-rays of the head will tell whether a person is likely to become insane. (N.10)

6. It is usually physical causes that bring on mental disorder. (N.10 modif.)

7. Insanity is not a hopeless condition. (N.6 modif.)

8. It is not surprising if someone who has been very ill develops mental trouble.

9. The insane laugh more than normal people. (N.1)

10. Brain fag brings on mental illness in many cases. (S. modif.)

11. If you get treatment for mental illness early enough you can be completely cured. (B)

12. People who are mentally ill really deserve pity. (B. modif.)

13. Drink is one of the main causes of mental illness. (S. modif.)

14. People nowadays are not ashamed of mental illness in their families.

15. There have been great advances in the treatment of the mentally ill since the years before the war.

16. One of the main causes in mental illness is lack of moral strength.

17. Mental patients usually settle back into ordinary life quite easily when they are discharged from hospital. (N.6 modif.)

18. A person who has plenty of affection as a child is not likely to develop a mental illness. (S. modif.)

19. You can tell someone who is mentally ill from their appearance. (N.1 modif.)

20. It is possible to get rid of unpleasant memories by trying hard to forget them. (N.4 modif.)

21. Close association with mentally ill people is liable to make even a normal person break down. (N. 5 modif.)

22. Someone with a nervous breakdown needs sympathy more than anything.

23. The loss of a parent due to separation or divorce may cause mental illness.

24. There is not much that can be done for someone who develops a mental disorder. (N.6)

25. A person can avoid worry by keeping busy. (N)

26./

26. Some families just have a bad streak ofmental trouble in them and there is not much anyone can do about it.

27. Intemperate and evil habits will cause mental illness.

28. Most of the people in mental hospitals speak in a way that can be understood. (N.1)

29. People who are very religious may have a mental breakdown.

30. Mental illness is one of those things it's best not to talk about. (B)

31. Nervous breakdowns seldom have a physical cause. (N.10 modif.)

32. Will power alone can cure most mental troubles. (N.2 modif.)

33. Mental illness is just an illness like any other. (B. modif.)

34. Nervous illness can often be helped by going on holiday or having a change of scene.

35. Women are more likely to have nervous breakdowns than men. (N.3 modif.)

36. If someone's imagination is too vivid they may end by developing mental illness.

37. A mental patient is in no position to make decisions about everyday living problems.

38. People who are mentally ill seem to live in a different world from the rest of us. (B)

39. An unhappy home life is the main cause of mental illness.

40. Mental illness makes people so different from the rest of us that it's hard to have ordinary feelings about them.

41. It is important to take a good diet to avoid nervous troubles. (N. modif.)

42. The stress and strain of present day living brings on mental illness.

43. Women are just as emotionally healthy as men. (N.3 modif.)

44. Mental illness seems to run in families. (N.4 modif.)

45. People may commit suicide when they are mentally disturbed.

46. The mentally ill should not be allowed to mix with ordinary people. (B)

47./

47. When a person's mind is ill it's just like losing them altogether.

48. Insanity can be brought on by a severe blow on the head.

49. You never know what someone who is mentally ill is planning and it may be harmful. (B)

50. A change of climate seldom helps an emotional disorder. (N.7)

51. People in their teens are especially liable to develop mental illness. (N.9 modif.)

52. Experts themselves often can't agree on whether a man is mentally ill enough to be put in a mental hospital or not.

53. The eyes of the insane are glassy. (N)

54. Job worries can be the cause of mental breakdown. (N.7 modif.)

55. To have a nervous breakdown is one of the most serious illnesses anyone can have. (N. modif.)

56. A severe shock in early life may cause mental illness later.

57. People usually recover from nervous breakdowns.

58. Mental illness often results from physical illness. (N.10 modif.)

59. If a marriage is unhappy mental illness may result.

60. There is something about mentally ill people that makes it easy to tell them from normal people.

61. Children of divorced parents are more liable than others to develop mental illness.

62. Worry and anxiety can cause mental illness.

63. Some of the things that the medical people do in treating mental illness are just plain guesswork and they may do more harm than good.

64. Crimes of violence should be punished by flogging.

65. Women have no more emotional problems than men. (N.3 modif.)

66. The mentally ill are a bit like naughty children. (B)

67. Overwork is one big cause of mental breakdown.

68. As soon as a person shows signs of mental disturbance he should be hospitalised.

69./

69. If a person is ill-treated as a child they may become mentally ill when they grow up.

70. Grief and bereavement can cause a person to become mentally ill.

71. Most of the people who seem to be cured will be back for more treatment later on.

72. Let's face it, the mentally ill can be a funny lot. (B)

73. Mental illness is the worst sort of illness anyone can have. (N.8 modif.)

74. If people are made to feel they are not wanted when they are children they may develop mental illness when they become adults.

75. The doctors and psychiatrists who deal with mental illness know exactly what they are doing. (B)

76. Disagreements in the home are often the cause of nervous breakdowns.

77. The insane are dangerous.

78. Mental illness can be avoided by avoiding morbid thoughts. (N.4 modif.)

79. To become insane is one of the worst things that could happen to anyone. (N. modif.)

80. Younger people have more emotional problems than old people. (N)

81. Few people who enter a mental hospital ever leave it. (N.3).

82. People who are mentally ill don't care about their personal appearance.

83. Abnormal people are ruled by their emotions, normal people by their reason.

84. Mental illness is just another illness and can be cured like any other illness. (B)

85. If there's been a mental illness in your family, the sensible thing is to keep it hushed up. (B)

86. Many people with mental illness bring it on themselves. (B)

87. Modern methods of treatment can cure insanity.

88. It is lack of friends and human companionship that makes some people mentally ill.

89. Worry over money difficulties can cause mental illness. (N.7 modif.)

90. Mental illness can be caused by disagreement or tension which existed between one's parents.

SECTION V

ESTIMATES OF SOCIAL DISTANCE BETWEEN RESPONDENT AND HYPOTHETICAL EX-PATIENT OR OUT-PATIENT

I would like you to consider something slightly different next. Suppose you met someone who you were told had recently been treated for a nervous breakdown, I wonder how you might feel about them. I'd like you to imagine first that this person is a woman. Here are some of the feelings you might have about them.

Just put the feelings that you agree with into this box at the end (indicate AGREE box).

43. Hand the respondent 12 Set B cards inscribed thus:-

I'd feel sympathy with them.
I'd feel a bit uneasy.
I'd feel rather repelled by them.
I'd wonder what was going on under the surface.
I'd feel rather strange and embarassed with them.
I'd feel I wanted to avoid them.
I wouldn't like to be left alone with them for long.
I'd feel they couldn't be trusted.
I'd feel it was unfair to people who didn't know.
I'd feel they really shouldn't be mixing with other people.
I'd feel less respect for them than for ordinary people.
I'd feel I had to be careful not to upset them.

(After checking off the numbers of the statements which the respondent agrees with, reshuffle the pack of 12 cards.)

44. If this person who'd had a nervous breakdown was a man how would you feel? Just go through the cards once more and put the feelings you agree with into this box again (hand cards to respondent and check numbers of agree cards again and reshuffle).

45. Supposing you knew of a man who had been a patient in a mental hospital for a year, what would your feelings towards him be like? Just put the statements you agree with in this case back in the box, please.

(Hand reshuffled cards back.)

46./

46. Would you feel the same or different towards a woman who had been a mental patient in hospital for a year?
Same = 1; Different = 2; Don't Know = 3.

47. If different, ask -
In what way would you feel different?

48. If you discovered that a person you know was having regular out-patient treatment at a mental hospital how would you feel?

(Hand set of 18 C cards to respondent.)

LIST OF C. STATEMENTS:

1. I'd feel a bit strange and embarassed with them.
2. I'd be glad he or she was getting treatment or help.
3. I wouldn't like to be left alone for long with them.
4. I'd feel a bit uneasy.
5. I'd never feel quite the same towards this person.
6. I'd feel a bit strange and embarassed with them.
7. I'd feel it was unfair to the people who didn't know about them.
8. I'd feel they really ought to be kept in a mental hospital while ill and not allowed to mix freely with other people.
9. I'd feel sympathy for them.
10. I'd feel it was unfair to the people who didn't know.
11. I'd hope they would get well quickly.
12. I'd wonder what was going on under the surface.
13. I'd feel rather repelled by them.
14. I'd feel I wished I could help in some way.
15. I'd feel that somehow they couldn't be trusted.
16. I'd feel less respect for them than for ordinary people.
17. I'd feel I had to be careful not to upset them.
18. I'd feel I wanted to avoid them.

(Remove "AGREE" C cards, store them separately from those the respondent has rejected.)

49. I'd just like to carry this one stage further. If somebody you knew had once had treatment for some sort of mental trouble it might affect the way you reacted to them afterwards.

For/

For example,

Would you mix freely with them socially?
Yes = 1; No = 2; Don't Know = 3.
Would you be prepared to work next to them?
Yes = 1; No = 2; Don't Know = 3.
Would you introduce them to your close friends?
Yes = 1; No = 2; Don't Know = 3.
Would you let them look after (your) children?
Yes = 1; No = 2; Don't Know = 3.
Would you like having them to live next door?
Yes = 1; No = 2; Don't Know = 3.
Would you mind mixing with them outside, in the shops or street? Yes = 1; No = 2; Don't Know = 3.
Would you ever go the length of discussing your own personal affairs with them?
Yes = 1; No = 2; Don't Know = 3.
Would you, as an employer, give such a person a job?
Yes = 1; No = 2; Don't Know = 3.
Would you yourself work for someone like this?
Yes = 1; No = 2; Don't Know = 3.
Would you approve of someone like this marrying into your family? Yes = 1; No = 2; Don't Know = 3.
Would you think they could hold a responsible position?
Yes = 1; No = 2; Don't Know = 3.

SECTION VI

SELF-ESTIMATE OF RESPONDENT'S TOLERANCE FOR THE MENTALLY ILL

You've provided me with a good picture of your feelings about these people.

50. Would you say that you regard yourself as sympathetic towards people, who've once been mental patients?
Yes = 1; No = 2; Don't Know = 3.

51. Do you think you should show more sympathy?
Yes = 1; No = 2; Don't Know = 3.

52. What about the people round here, would you say they are sympathetic about these things?
Yes = 1; No = 2; Don't Know = 3.

SECTION/

SECTION VII

ESTIMATE OF POSSIBLE STIGMA ATTACHED TO MENTAL ILLNESS IN A MEMBER OF THE RESPONDENT'S IMMEDIATE FAMILY

Sometimes it is hard to imagine your reactions to strangers.

53. But if someone in your own family became ill and needed to be admitted to a mental hospital, would you -

Tell your relatives? Yes=1; No=2; Don't Know=3.
try to conceal it from neighbours? Yes=4; No=5; Don't Know = 6.
tell employees who might be concerned? Yes=7; No=8; Don't Know=9.
mention it to other people?
just as if it was a physical illness? Yes=0; No=X; Don't Know=Y.

SECTION VIII

RESPONDENTS ESTIMATE OF CHANGES OVER TIME IN LOCAL ATTITUDES TO MENTAL ILLNESS AND ITS CURE, MENTAL PATIENTS and MENTAL HOSPITALS

Some people say that ideas are changing nowadays on these subjects.

54. Do you consider there has been any change since before the war? (or, in the last 20 years; or, since you were a child?). Yes = 1; No = 2; Don't Know = 3.

55. If Yes, For example, do you think people are behaving better now towards mental patients?
Better = 1; No Better = 2; Don't Know = 3.

56. Do you think that the chances of successful treatment for nervous breakdown are better? Yes = 1; No = 2;
Don't Know = 3.

57. What about the treatment of mental illness? Is is better?
Yes = 1; No = 2; Don't Know = 3.

58. Do you think that there is a better chance of curing insanity? Yes = 1; No = 2; Don't Know = 3.

59./

59. Would you say people are - More afraid = 1;
Less afraid = 2, of going to mental hospital for treatment now than they used to be?

SECTION IX

GOUGH-SANFORD RIGIDITY SCALE (modified)

60. Before we finish there is just one more set of cards to sort. Again, just as we did earlier on, this is a matter of reading the statement and deciding how much you agree or disagree with it. That is to say, you've got a choice of all these boxes to post them in, according to how far the statement agrees with you're own point of view. If you don't agree use this end of the line of boxes, if you agree use this end.

(Hand respondent 21 D. cards.)

D. CARDS:

1. I'm often the last person to give up trying to do something.
2. I think that there is normally only one best way of solving most problems.
3. I really prefer work that needs a lot of attention to detail.
4. I often get to wrapped up in something I'm doing that I find it difficult to switch my attention to other matters.
5. I dislike having to change my plans in the midst of something.
6. I never miss going to church.
7. I generally stick to my own opinions even although lots of other people think differently.
8. I find it easy to stick to a certain schedule once I've got started on it.
9. I don't enjoy having to get used to new situations.
10. Even on quite small matters, I prefer to stop and think before it act.
11. I try to follow a plan of life based on duty.
12. Usually I find my own way of tackling a problem is best, even if it doesn't seem to work in the beginning.
13. I am a methodical person in everything I do.
14. It is usually wise to do things in a conventional way.
15. I always finish jobs I set out on, if they aren't very important.

16./

16. Often I find myself thinking of the same tunes or phrases for days on end.
17. I generally make a point of checking several times that I've locked a door or put out a light at night.
18. I've never done something dangerous just for the thrill of it.
19. Promptness in meeting appointments is very important.
20. I am always careful about my manner of dress.
21. I always put on and take off clothes in the same order.

SECTION X

RESPONDENT'S FINAL WORD

61. You have been very helpful in replying patiently to so many questions. These viewpoints you have given are going to be very useful to us in our study. There is just one final question I'd like to put to you. In your own words, what would you say is the recipe for avoiding mental or nervous illness?

INTERVIEWER'S RATINGS

Did you feel that the respondent was co-operative?
very co-operative?
rather unco-operative?
very unco-operative?
can't say?

Did you feel that the respondent was being frank and honest in his answers?
Completely so?
usually?
frequently not so?
usually not so?
can't say?

Did you get the impression that the respondent was at all disturbed by the content of the interview?
Very disturbed?
rather disturbed?
slightly disturbed?
not at all disturbed?
can't say?

Time of interview.

Date of interview.

Location of interview: Home
Other (specify)

Home address of respondent:

Interviewer's signature:

APPENDIX I
(Continued)

SUMMARY OF FIRST DRAFT QUESTIONNAIRE

HEALTH OPINION SURVEY

Summary.

Sections of Questionnaire

INTRODUCTION: Designed to set the respondent at their ease, to explain the importance of their viewpoint and personal experiences and to assure them of privacy and anonymity.

SECTION I Personal demographic data on age, sex, education, income, etc.

SECTION II Respondent's personal experience of mentally ill persons, mental hospitals and people who were deviant without being defined as mentally ill.

SECTION III Respondent's sources of knowledge and information regarding mental illness, nervous breakdowns, insanity and mentally ill people.

SECTION IV Attitudes and opinions regarding mental patients and the cause and cure of mental illness. This section aims to receive graded responses to a series of 90 attitude and opinion statements derived from Nunnally, Belson, Star and others. The method used is to require statements on individual cards to be placed in boxes which indicate the respondent's degree of agreement or disagreement with the stated views.

SECTION V Estimates of social distance between the respondent and hypothetical ex-mental patients or out-patients. The respondent is asked to consider in succession his acquaintance with a woman who has recently had a nervous breakdown, a man with the same experience, a man or woman who had been in a mental hospital for a year, someone who was having regular out-patient treatment at a mental hospital. Cards with statements of opinion/

SECTION V (Cont/-)

opinion are presented for sorting by extent of the respondent's agreement or disagreement. The statements are based upon those used by Belson. They are succeeded by statements of differing degrees of social distance or nearness which the respondent says he would observe towards someone known to have had treatment for some sort of mental illness.

SECTION VI — Self estimate of respondent's tolerance of the previously mentally ill by comparing his own account of his sympathy with the sympathy he ought to show and that which he considers local people show (after Foulds).

SECTION VII — Estimate of possible stigma which would attach to mental illness in a member of the respondent's immediate family.

SECTION VIII — Respondent's estimate of changes over time in local attitudes to mental illness and its cure, mental patients and mental hospitals.

SECTION IX — A measurement or estimate of the respondent's relative rigidity or flexibility of personality, made by presenting him with a modification of the Gough-Sanford Rigidity Scale. A series of over 20 statements expressive of inflexible behaviour are submitted for sorting by degrees of agreement or disagreement.

SECTION X — Finally the respondent is asked to give their own recipe, in their own words, at greater or shorter length, of a recipe for the avoidance of mental breakdown.

INTERVIEWER'S RATINGS

Of respondent's co-operation
honesty
and possible disturbance.

Date and time of interview and interviewer's signature.

APPENDIX II

QUESTIONNAIRE SUBMITTED TO SCOTTISH PSYCHIATRIC CONSULTANTS

and

Accompanying Letter

APPENDIX II

QUESTIONNAIRE SUBMITTED TO SCOTTISH PSYCHIATRIC CONSULTANTS

COMMUNITY ATTITUDES AND OPINIONS REGARDING MENTAL ILLNESS

The following is a list of statements which have been made by members of the general public regarding the cause, course and cure of mental illness. We are anxious to obtain your own personal opinion on each of these statements. Your reaction may be to disagree strongly; alternatively, you may strongly agree, you may agree or disagree to a lesser extent or you may be uncertain about it. Please indicate your own personal opinion by putting a tick (✓) in the appropriate column, opposite each opinion statement. Thank you for your co-operation.

A. OPINIONS ON THE CAUSES OF MENTAL ILLNESS

	Strongly agree	Agree	Uncertain	Disagree	Strongly Disagree
1. Most mental troubles in adults are due to experiences they had as children.					
2. Rest won't prevent mental disorders.					
3. It is generally accidents or illness that bring on mental illness.					
4. Drink is one of the main causes of mental illness.					
5. People who are very religious tend to develop mental illness.					
6. /					

		Strongly agree	Agree	Uncertain	Disagree	Strongly Disagree
6.	Women are more likely to have mental illness than men.					
7.	People with a very vivid imagination may be liable to develop mental illness.					
8.	An unhappy home life is one of the main causes of mental illness.					
9.	A good diet can really help to prevent mental illness.					
10.	Much mental illness is the result of the stress and strain of present day living.					
11.	Mental illness runs in families.					
12.	A severe blow on the head may bring on mental illness.					
13.	A change of climate seldom helps a developing mental illness.					
14.	Job worries can bring on mental illness.					
15.	Worry and anxiety often cause mental illness.					
16.	Overwork is a big cause of mental illness.					
17.	Grief and bereavement may make some people mentally ill.					
18./						

	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
18. Children who are made to feel they are not wanted may develop mental illness when they grow up.					
19. Mental illness can be avoided by avoiding gloomy thoughts.					
20. Loneliness and lack of friends makes some people become mentally ill.					
21. Money worries are a big cause of mental illness.					
22. One of the main causes of mental illness is lack of moral strength.					
23. Sexual over-indulgence will end for some people in mental illness.					
B. OPINIONS ABOUT THE COURSE AND PROSPECTS OF CURE FOR MENTAL ILLNESS					
1. Mental illness is not a hopeless condition.					
2. If you get treatment for mental illness early enough you can be completely cured.					
3. There have been great advances recently in the treatment of the mentally ill.					

4./

	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
4. Mental patients usually settle back into ordinary life quite easily when they are discharged from hospital.					
5. There is not much that can be done for someone who develops a mental illness.					
6. Will power alone can cure most mental troubles.					
7. Mental illness can often be helped by a holiday or change of scene.					
8. To develop a mental illness is one of the worst things that could happen to anyone.					
9. Few people who enter a mental hospital ever leave it.					
10. Most of the mentally ill people who seem to be cured will be back for more treatment later on.					

Catherine M.U. Maclean, M.D., D.P.H.
Medical Research Council
Unit for Research on the Epidemiology of Psychiatric Illness
Edinburgh University Department of Psychiatry
Royal Edinburgh Hospital
Morningside Park
EDINBURGH 10.

APPENDIX II
(Continued)

DRAFT OF LETTER SENT TO
SCOTTISH PSYCHIATRIC CONSULTANTS

Dear ..... ,

I am engaged in a study of Community Attitudes to Mental Illness and to Mental Patients and I am designing a questionnaire which I plan ultimately to use on a sample of the population of Edinburgh.

In drawing up the section of the questionnaire which deals with popular opinions about the cause, course and cure of mental illness I have culled statements from a wide variety of sources. I am anxious to have a note of the extent to which practising psychiatrists in Scotland agree or disagree with these statements in order that I may develop 'Sophistication' scores for my sample. It would greatly assist me if you could personally find the time to indicate your opinions on the accompanying sheet.

Any additional comments which you have to offer regarding, for example, statements which seem to you ambiguous or confusing, would of course be most welcome.

I should add that this study has the full support of Professor Carstairs and is under the supervision of Dr. Graham Foulds.

Yours sincerely,

(Signed) UNA MACLEAN, M.D.

APPENDIX III

QUESTIONNAIRE SUBMITTED TO SCOTTISH PSYCHIATRIC CONSULTANTS

and

ACCOMPANYING LETTER

APPENDIX III

SECOND DRAFT QUESTIONNAIRE: FOR PILOT SURVEY

UNIVERSITY OF EDINBURGH

HEALTH OPINION SURVEY (PILOT)

INTERVIEWER'S NAME: TIME STARTED:

SCHEDULE NUMBER: DATE:

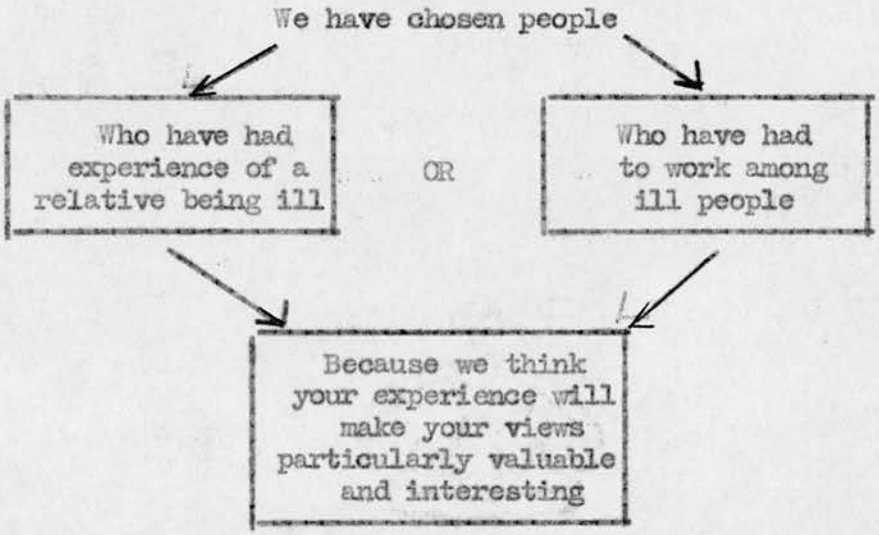
INTRODUCTION

I'm from Edinburgh University. We are doing a study of how much people know about certain health problems and it would be a great help if you could answer some questions.

(Further reassurance) - Of course anything you say will be treated as confidential and your name will not appear.

(If further explanation of reason for choice of respondent is needed) -

We/



QUESTION 1

(HAND RESPONDENT CARD). Here is a list of some different kinds of illnesses that people may have. Which of these would you yourself least like to have? (MARK FIRST MENTIONED WITH NUMBER 'ONE')

Which is the next most serious?

And the next .....? (MARK EACH IN RANK ORDER FOLLOWING THE FIRST)

CARD ONE

DIABETES	___	HEART DISEASE	___
INSANITY	___	CANCER	___
STOMACH ULCER	___	NERVOUS BREAKDOWN	___
TUBERCULOSIS	___	ARTHRITIS	___
MENTAL ILLNESS	___	EPILEPSY	___

QUESTION/

QUESTION 2

Now, following on from what you've just told me, I'd like to find out how much experience you've had with people who were mentally ill.

How many people like this have you known? (TICK WHICH APPLIES).

QUESTION 3

None - One - More than one - Note Total ___ Many

3b. (IF MORE THAN ONE OR MANY)

Were they relatives or friends or casual acquaintances or did you know them in the course of your work?

(NOTE NUMBER)

Relatives ___

Friends ___

Acquaintances ___

Met at work ___

3a. (IF ONE)

Was this person a relative or a friend, or a casual acquaintance?

(TICK)

Relative ___

Friend ___

Acquaintance ___

QUESTION/

QUESTION 4

Have you ever visited a mental hospital or a clinic or a nursing home for mental disorders?

Yes - No -

QUESTION 5

(IF YES)

Can you tell me where and when that was?

(IDENTIFY PLACE OR PLACES VISITED AND TIME)

QUESTION 6

Now I'd like you to tell me about other ways you may have got information about mental illness. For example, during the past three months, have you seen any programme on T.V. which mentioned it or which showed someone who was mentally ill?

Or have you heard any programme which mentioned it? Or heard a talk or lecture on the subject? Or perhaps you've had conversations about it with other people, or read about it.

(HAND RESPONDENT CARD AND TICK APPROPRIATE COLUMN(S))

CARD TWO

During the past three months, have you come across the subject of mental illness.

1. On T.V. ____
2. On the radio ____
3. In a talk or lecture ____
4. In a newspaper article ____
5. On a film ____
6. In conversation ____

QUESTION 7

I'm coming to something slightly different now. On these cards which I'm going to give you to sort there are a lot of different statements which people have made on the subject of mental illness. You may agree with some of these statements and disagree with others. Some of them you may feel that you have no opinion on some of the statements.

I would like you to place them one by one into these separate piles (POINT TO PILES) according to your own feelings of agreement or disagreement. There are no right or wrong answers to this. What we are interested in is your personal opinion.

Let me give you an example, on a different subject altogether - the weather!

(HAND RESPONDENT WEATHER CARD)

WEATHER CARD

In Edinburgh the summers are always very hot.

Do you agree or not? Just put it into the pile which corresponds to your own feelings about it .....

Here are the cards which I want you to sort .....

(HAND RESPONDENT SET OF NUMBERED OPINION AND ATTITUDE CARDS, IN ORDER)

(A, ATTITUDES)	S.A.	A.	U.	D.	S.D.
A 1. The mentally ill are dangerous.					
A 2. The mentally ill should be confined to hospital.					
A 3. People who have become mentally ill are to be pitied.					

A 4./

	S.A.	A.	U.	D.	S.D.
A 4. Close association with people who are mentally ill is liable to make a normal person break down.					
A 5. Mental illness is something it is best not to talk about.					
A 6. As soon as someone starts to show signs of mental disturbance they should be put in hospital.					
A 7. Mentally ill people seem to live in a different world from the rest of us.					
A 8. The mentally ill are rather like naughty children.					
A 9. Sometimes it's difficult to think of the mentally ill as ordinary human beings.					
A10. Mentally ill people are ruled more by their emotions than normal people are.					
A11. Most people with mental illness have brought it on themselves.					
A12. The mentally ill are really a funny lot.					
A13. People who are mentally ill should not be allowed to mix with ordinary people.					
A14. /					

	S.A.	A.	U.	D.	S.D.
A14. It is sympathy which the mentally ill need more than anything.					
(B, OPINIONS)					
B15. Most mental troubles in adults are due to experiences which they had as children.					
B16. Rest won't prevent mental disorders.					
B17. It is generally accidents or illness that bring on mental illness.					
B18. Drink is one of the main causes of mental illness.					
B.19 People who are very religious tend to develop mental illness.					
B20. Women are more likely to have mental illness than men.					
B21. An unhappy home life is one of the main causes of mental illness.					
B22. A good diet can really help to prevent mental illness.					
B23. Much mental illness is the result of the strain and stress of present day living.					
B24. Mental illness runs in families.					
B25. A severe blow on the head may bring on mental illness.					
B26. /					

	S.A.	A.	U.	D.	S.D.
B26. A change of climate seldom helps a developing mental illness.					
B27. Job worries can bring on mental illness.					
B28. Overwork is a big cause of mental illness.					
B29. Grief and bereavement may make some people mentally ill.					
B30. Children who are made to feel they are not wanted may develop mental illness when they grow up.					
B.31 Mental illness can be avoided by avoiding gloomy thoughts.					
B32. Loneliness and lack of friends make some people become mentally ill.					
B33. Money worries are a big cause of mental illness.					
B34. One of the main causes of mental illness is lack of moral strength.					
B35. Sexual overindulgence will end for some people in mental illness.					
(C, OPINIONS)					
C36. Mental illness is not a helpless condition.					
C37. /					

	S.A.	A.	U.	D.	S.D.
C37. If you get treatment for mental illness early enough you can be completely cured.					
C38. There have been great advances recently in the treatment of the mentally ill.					
C39. Mental patients usually settle back into ordinary life again quite easily when they are discharged from hospital.					
C40. There is not much that can be done for someone who develops a mental illness.					
C41. Mental illness can often be helped by a holiday or change of scene.					
C42. To develop a mental illness is one of the worst things that could happen to anyone.					
C43. Few people who enter a mental hospital ever leave it.					
C44. Most of the mentally ill people who seem to be cured will be back for more treatment later on.					
(D, OPINIONS)					
D45. The mentally ill are inclined to laugh more than ordinary people.					
D46. /					

	S.A.	A.	U.	D.	S.D.
D46. You can easily tell the mentally ill from their appearance.					
D47. The eyes of the mentally ill are glassy.					
D48. Most patients in mental hospitals can carry on a sensible conversation.					
D49. When a person becomes mentally ill it's just like losing them altogether.					
D50. The mentally ill don't care about their personal appearance.					
D51. People who are mentally ill are liable to commit suicide.					
D52. The mentally ill are unreliable, you never know what they will do next.					

QUESTION 8/

QUESTION 8

This time I would like you to tell me what your reactions would be to four people whom I'm going to describe to you.

Imagine that you have met someone recently who seems alright to you. Then you are privately told something about them.

(b) In the first case it is a woman, whom, you are told, has had a nervous breakdown. Which of these reactions would you have to her?

(HAND RESPONDENT 'WOMAN' CARD, AND TICK FEELINGS WITH WHICH RESPONDENT AGREES)

(WOMAN)

You find that a woman whom you have met recently has had a nervous breakdown.

Would you be glad she had been having treatment? ___

Would you feel sympathy for her? ___

Would you feel a bit uneasy? ___

Would you feel rather repelled by her? ___

Would you wonder what was going on under the surface? ___

Would you feel you wanted to avoid her? ___

Would you dislike being left alone with her for long? ___

Would you feel she couldn't be trusted? ___

Would you feel it was unfair to people who didn't know? ___

Would you feel she really shouldn't be mixing with other people? ___

Would you feel less respect for her than for ordinary people? ___

Would you feel you had to be careful not to upset her? ___

Would you wish you could help her in some way? ___

(b) Now imaging this time that the person you have met and been told about is <u>a man who has had a nervous breakdown</u>.

(HAND RESPONDENT 'MAN A' CARD, AND TICK APPROPRIATE ANSWERS)

(MAN A)

You find that a man whom you have met recently has had a nervous breakdown.

Would you feel sympathy for him? ___

Would you feel rather repelled by him? ___

Would you feel you wanted to avoid him? ___

Would you feel he couldn't be trusted? ___

Would you feel he really shouldn't be mixing with other people? ___

Would you feel you had to be careful not to upset him? ___

Would you be glad he had been having treatment? ___

Would you feel a bit uneasy? ___

Would you wonder what was going on under the surface? ___

Would you dislike being left alone with him for long? ___

Would you feel it was unfair to people who didn't know? ___

Would you feel less respect for him than for ordinary people? ___

Would you wish you could help him in some way? ___

(c) Next, imagine that the person whom you've been told about is a man, whom you learn has spent a year in a mental hospital.

(HAND RESPONDENT 'MAN B' CARD, AND TICK APPROPRIATE ANSWERS)

(MAN B)

You find that a man whom you have met has spent a year in a mental hospital.

Would you wish you could help him in some way? ____

Would you feel you had to be careful not to upset him? ____

Would you feel less respect for him than for ordinary people? ____

Would you feel he really should not be mixing with other people? ____

Would you feel it was unfair to people who didn't know? ____

Would you feel he couldn't be trusted? ____

Would you dislike being left alone with him for long? ____

Would you feel you wanted to avoid him? ____

Would you wonder what was going on under the surface? ____

Would you feel rather repelled by him? ____

Would you feel a bit uneasy? ____

Would you feel sympathy for him? ____

Would you be glad he had been having treatment? ____

Finally, this time the person you're going to think about is someone who, you're told, is under treatment from their doctor for a mental illness.

Please tell me what your feelings this time would be .....

(HAND RESPONDENT CARD X AND TICK REPLIES AS BEFORE)

CARD X

Would you wish you could help them in some way?	___
Would you feel less respect for them than for ordinary people?	___
Would you feel it was unfair to people who didn't know?	___
Would you dislike being left alone with them for long?	___
Would you wonder what was going on under the surface?	___
Would you feel a bit uneasy?	___
Would you be glad they had been having treatment?	___
Would you feel you had to be careful not to upset them?	___
Would you feel they really shouldn't be mixing with other people?	___
Would you feel they couldn't be trusted?	___
Would you feel you wanted to avoid them?	___
Would you feel rather repelled by them?	___
Would you feel sympathy for them?	___

QUESTION 9

Nowadays it is quite possible that you may come across people who have once been patients in a mental hospital. I'd like to discover how you would react to someone whom you know has once had three months treatment in a mental hospital.

Again, this is simply a matter of telling me which statement you agree with .....

(HAND RESPONDENT CARD Y AND PROCEED TO TICK REPLIES AS BEFORE)

CARD Y

If you knew that someone had three months treatment in a mental hospital, would you be willing:

1. To mix freely with them socially? ___
2. To work next to them at the same job? ___
3. To let them baby sit for your children? ___
4. To introduce them to your close friends? ___
5. To mix with them in the shops or street? ___
6. To have them hold a responsible position? ___
7. To have them marry someone close to you? ___
8. To discuss your personal affairs with them? ___
9. To have them live next door to you? ___
10. To let them teach your children? ___
11. To give them a job, if you were an employer? ___
12. To work for them, as an employee? ___

QUESTION 10/

QUESTION 10

I wonder how many mental patients you think need to be certified nowadays?

Is it less than 5 per cent of all the patients ____

or 10 per cent ____

or 30 per cent ____

or more than 30 per cent ____

QUESTION 11

Can you tell me how far you agree with this statement? You may

strongly agree
or agree somewhat
or disagree somewhat
or strongly disagree

(HAND RESPONDENT CARD Z AND TICK ANSWER GIVEN BY RESPONDENT)

CARD Z

"People should be expected to handle their own problems"

Do you:
strongly agree ____
agree somewhat ____
disagree somewhat ____
strongly disagree ____

QUESTION 12

In your opinion, do you feel that the amount of tolerance towards the mentally ill is changing?

Yes ____ No ____ Don't know ____

(IF/

(IF YES)

Are people in Edinburgh:

more tolerant ____

or

less tolerant ____

to the mentally ill now than they were before the Second World War?

QUESTION 13

Finally, to finish the main part of these inquiries, I'd like you to tell me what you think is the best recipe for avoiding mental troubles? (TAKE DOWN RESPONDENT'S OWN WORDS)

PERSONAL DATA

QUESTION 14

SEX

QUESTION 15

AGE

(IF AGE NOT GIVEN SHOW RESPONDENT AGE GROUP CARD)

AGE GROUP	
up to 19	40 - 44
20 - 24	45 - 49
25 - 29	50 - 54
30 - 34	55 - 59
35 - 39	65 and over

QUESTION 16

STATUS OF SUBJECT

Married	M
Single	S
Widowed	W

QUESTION 17

DEPENDENT CHILDREN IN HOUSEHOLD YES. NO.

IF YES, GIVE AGE AND SEX

1	____	____
2	____	____
3	____	____
4	____	____
5	____	____

QUESTION 18

SUBJECT HOUSEWIFE Yes ___

No ___

QUESTION 19

SUBJECT EMPLOYED Yes ___

No ___

Other (Specify) _____

(IF 'YES' ASK ABOUT PRESENT JOB. IF 'NO' ASK ABOUT LAST JOB)

SUBJECT'S OCCUPATION (full description)

_____

_____

SUBJECT'S INDUSTRY, TRADE OR PROFESSION

_____

_____

Self-employed 1. ___ In charge of others ___

Employee 2. ___

QUESTION 20

EDUCATION

PRIMARY ONLY _____

SECONDARY _____

Type of secondary education	_____
Age at completion	_____

POST SECONDARY _____

_____

Specify type

_____

QUESTION 21

RELIGIOUS DENOMINATION _____

_____

Regular church attender ____

Occasional attender ____

Never attends ____

_____

QUESTION 22

LENGTH OF RESIDENCE IN EDINBURGH IN YEARS _____

QUESTION 23

BIRTH PLACE _____

QUESTION 24

WHERE FIRST TEN YEARS OF LIFE WERE SPENT _____

CALL BACK. MAY CALL BACK _____ 1

MAY NOT CALL BACK OR DOUBTFUL _____ 2

TIME OF ENDING INTERVIEW _____

INTERVIEWER'S NOTES:

APPENDIX III
(Continued)

SAMPLE LETTER SENT TO RELATIVES
OF UPPER CLASS PATIENTS
REQUESTING AN INTERVIEW

Mrs. J.B.C.,
. . . . .,
EDINBURGH.

Dear Mrs. C.,

Under the direction of Professor Carstairs I am engaged in making a study of people's opinions and knowledge on a number of pressing health problems. In particular, we are anxious to find out the attitudes of members of the general public nowadays towards the subject of mental illness.

Dr. X has told me that she thinks you might be prepared to co-operate in our enquiries so I am approaching you directly. I would like, in the next few weeks, to have an opportunity of talking to you for about half an hour and asking you a few simple questions.

I should emphasize that these questions will not be of a personal nature, that your opinions will be treated in absolute confidence, and that you will remain anonymous as far as all records of our research are concerned.

Can you suggest what time would be most convenient for me to call on you? I am enclosing a stamped addressed postcard for your reply.

Looking forward to hearing from you,

I am,
Yours sincerely,

Dr. Catherine M.U. Maclean

APPENDIX IV

FINAL FORM OF QUESTIONNAIRE AS USED IN THE EDINBURGH SURVEY

APPENDIX IV

FINAL FORM OF QUESTIONNAIRE AS USED IN THE EDINBURGH SURVEY

CONFIDENTIAL Schedule No. _____

MEDICAL RESEARCH COUNCIL UNIVERSITY OF EDINBURGH

HEALTH OPINION SURVEY

FIELD SURVEY RECORDING SCHEDULE

	Introduction I am (x - y) from the Medical Research Council. We are doing a study of how much people know about certain health problems and it would be a great help to us if you could answer some questions. (Further reassurance) - Of course, anything that you tell me will be treated as completely confidential and your name will not be used at any stage. (If further explanation of choice of respondent is needed). We are talking to men and women throughout Edinburgh of all ages and different occupations, and your name happens to have come up. If final refusal - give reasons:	

1. OPINION QUESTION

To start with, I am going to ask you to look at this card - (HAND DIAGNOSIS CARD TO RESPONDENT)

You will see that it is a list of eight different kinds of illnesses. I'd like you to tell me which one of those you yourself would least like to have .....

And which would you say is the next most serious?

And the next? (MARK EACH IN RANK ORDER)

DIAGNOSIS CARD ONE

- Diabetes
- Insanity
- Arthritis
- Nervous Breakdown
- Heart Disease
- Stomach Ulcer
- Mental Illness
- Cancer

2. FACTUAL QUESTION

Now, on the subject of mental illness which was mentioned on that card, I'd just like to find out whether you've ever had any experience of people who were mentally ill.

Have you known anyone like that? YES / NO / PROMPT

PROMPTING PERMISSIBLE

(if YES) Have you just known one person? ONE

Or more than one? How many?

(If ONE or MORE THAN ONE, GO ON TO ASK REGARDING EACH PERSON WHETHER THEY WERE

a/

	a relative - note actual relationship a friend an acquaintance someone met at work other (specify, e.g. self)	
2a. FACTUAL QUESTION	About this person (these people) you've mentioned, can you tell me whether they were friends or relatives ... etc. or how you would describe them? Parent (Mother / Father) Spouse Sibling (Brother / Sister) Child (Son / Daughter) Other relative Friend Acquaintance Workmate Other	
3. FACTUAL QUESTION	Have you ever, at any time, visited a mental hospital, or an asylum or a clinic or nursing home where mental disorders are treated? YES NO (If YES) Can you tell me where that was? (NAME OF INSTITUTION): And how long ago? (APPROXIMATE TIME, TO NEAREST YEAR):	

4. FACTUAL QUESTION

Now I'd like to talk about some of the other ways that people find out information about mental illness.

Can you recall whether you've noticed anything on this subject in the past three months. (HAND RESPONDENT CARD TWO AND PROMPT FOR EACH MEDIUM IN TURN).

	MASS MEDIA	CARD TWO	
i	on television, for example?	YES	
ii	on the radio?	YES	
iii	in a talk or a lecture?	YES	
iv	in a newspaper or magazine?	YES	
v	in a film?	YES	
vi	in conversation?	YES	

4a. FACTUAL QUESTION PROMPTING PERMISSIBLE

(If YES to any of the mass media, i - v) I'd like you to tell me a bit more about that .....

What was the programme (article, etc.) called?

Or can you remember what it was about?

Was it (a) a documentary or news programme? YES

(b) a medical/or doctor/or hospital programme? YES
(e.g. Dr. Kildare, Dr. Finlay's Casebook, Emergency Ward 10, etc.)

Specify:

(c) /

(c) a play? YES ☐

(d) any other programme or article? (ENTER ANY ADDITIONAL OR ALTERNATIVE ANSWERS, USING THE RESPONDENT'S OWN WORDS): YES ☐

5. OPINION QUESTION

Now I'm coming on to something slightly different.

On these cards, which I'm going to ask you to sort, there are a lot of different statements which people have made on the subject of mental illness.

You may agree with some of them and disagree with others.

Some of them you may feel quite strongly about.

NO PROMPTING OR PARAPHRASING

On the other hand, of course, you may feel in some cases that you have no opinion about some of the statements printed on the cards.

(MEANWHILE LAY OUT THE BOXES IN THEIR APPROPRIATE ORDER AND HAVE THE PACK OF 47 CARDS READY)

What I would like you to do is to read each one in turn and then to place it into one of these boxes, (POINT TO BOXES) according to your own feelings about the statements. That is to say, if you agree or disagree or if you agree strongly or disagree strongly, (INDICATE APPROPRIATE BOXES) or if you have no opinion about what is on the card.

Do you understand?

(PROCEED TO DEMONSTRATE WITH CARD THREE - WEATHER)

For/

For example, on a different subject altogether, the weather:

HAND
RESPONDENT
SAMPLE
CARD

WEATHER CARD THREE

In Edinburgh the summers are always very hot

Supposing you saw that statement, where would you put it?

Just put in into the pile which corresponds to your own feelings ..... Thank you.

Before we start, I'd like to point out that there aren't any right or wrong answers to this. Some people feel one way about these things and some people feel another way.

What we are interested in is your personal opinion.

Now here are the cards for sorting .....

(HAND RESPONDENT PACK OF 47 OPINION AND ATTITUDE CARDS, IN NUMERICAL ORDER, AND ALLOW THE SORTING WITHOUT INTERRUPTION.

IMPORTANT

NO PARAPHRASING IS PERMISSIBLE, THOUGH A STATEMENT CAN BE READ ALOUD, AND REPEATED, IF THE RESPONDENT IS IN DIFFICULTY.)

SCORE SHEET /

SCORE SHEET

47 OPINION AND ATTITUDE STATEMENTS

	Statement	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
1.	The mentally ill are dangerous					
2.	The mentally ill should be put away in institutions.					
3.	People who have become mentally ill are to be pitied.					
4.	Close association with people who are mentally ill is liable to make a normal person break down.					
5.	Mental illness is something it is best not to talk about.					
6.	Most women who were once patients in a mental hospital could be trusted as baby sitters.					
7.	As soon as someone begins to show signs of mental disturbance they should receive hospital treatment.					
8.	Mentally ill people seem to live in a different world to the rest of us.					
9./						

	Statement	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
9.	Most patients in mental hospitals still have to be kept there against their will.					
10.	Sometimes it's difficult to think of the mentally ill as ordinary human beings.					
11.	I would be willing for a member of my family to marry someone who had once been a mental hospital patient.					
12.	Mentally ill people are ruled more by their emotions than normal people are.					
13.	People who are mentally ill ought not to be allowed to mix with ordinary people.					
14.	What the mentally ill need more than anything is to have people show them sympathy.					
15.	A former mental patient could be trusted in a responsible position, as a lawyer, for example.					
16.	Rest won't prevent mental disorders.					
17/						

	Statement	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
17.	It is generally accidents or illness that bring on mental illness.					
18.	Drink is one of the main causes of mental illness.					
19.	An unhappy home life is one of the main causes of mental illness.					
20.	Much mental illness is the result of the strain and stress of present day living.					
21.	A change of climate seldom helps a developing mental illness.					
22.	Job worries can bring on mental illness.					
23.	Overwork is a big cause of mental illness.					
24.	Children who are made to feel they are not wanted may develop mental illness when they grow up.					
25.	Mental illness can be avoided by avoiding gloomy thoughts.					
26.	Money worries are a big cause of mental illness.					
27/						

	Statement	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
27.	One of the main causes of mental illness is lack of moral strength.					
28.	Sexual over-indulgence will end for some people in mental illness.					
29.	Mental patients usually settle back into ordinary life again quite easily when they are discharged from hospital.					
30.	Mental illness can often be helped by a holiday or change of scene.					
31.	To develop a mental illness is one of the worst things that could happen to anyone.					
32.	Few people who enter a mental hospital ever leave it.					
33.	Many of the mentally ill people who seem to be better will be back for more treatment later on.					
34.	I would be willing to have a former mental patient living next door.					
35.	The eyes of the mentally ill are glassy.					
36.	When a person becomes mentally will it's just like losing them altogether.					
37/						

	Statement	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
37.	I would be willing to work in a job alongside a former mental patient.					
38.	People who are mentally ill are liable to commit suicide.					
39.	The mentally ill don't care about their personal appearance.					
40.	I would let a former mental patient teach my children.					
41.	The mentally ill are unreliable, you never know what they will do next.					
42.	People nowadays are sufficiently tolerant towards the mentally ill.					
43.	Most patients in mental hospitals nowadays have gone in of their own free will.					
44.	Women at the change of life are very liable to become mentally ill.					
45.	A district nurse who had been a mental patient for a time could return to her job afterwards.					
46.	Sexual self-abuse may cause some young people to become mentally ill.					
47.	I think that in general people should be expected to handle their own problems.					

(AFTER COMPLETION OF SORTING, THANK THE RESPONDENT WHILST FILING THE CARDS IN APPROPRIATE MARKED AND NUMBERED ENVELOPES.)

6. We are nearly finished now.

OPINION QUESTION

I just want you to look at this list of 12 questions about the way you behave, feel and act. After each question there is a "YES" and "?" and a "NO".

Try and decide whether "YES" or "NO" represents your usual way of acting or feeling; then put a circle round the "YES" or "NO".

If you find it absolutely impossible to decide, put a circle round the "?" but don't use this answer except very occasionally.

Do it as quickly as you can. We want your first reaction to it. Don't miss out any questions.

Now go ahead, work quickly and remember to answer every question.

There are no right or wrong answers, and this isn't an intelligence test of any kind, just a measure of the way you behave.

(HAND RESPONDENT THE FOLLOWING PAGE, 10, OF THE SCHEDULE, OPENED OUT FLAT. PROVIDE PEN OR PENCIL FOR SCORING.

IMPORTANT

DO NOT PARAPHRASE.

IN EVENT OF DIFFICULTY, REPEAT INSTRUCTIONS AND, IF NECESSARY, READ QUESTION ALOUD.)

1.	ARE YOU HAPPIEST WHEN YOU GET INVOLVED IN SOME PROJECT THAT CALLS FOR RAPID ACTION?	Yes ? No
2.	DO YOU SOMETIMES FEEL HAPPY, SOMETIMES DEPRESSED WITHOUT ANY APPARENT REASON?	Yes ? No
3.	DOES YOUR MIND OFTEN WANDER WHILE YOU ARE TRYING TO CONCENTRATE?	Yes ? No
4.	DO YOU USUALLY TAKE THE INITIATIVE IN MAKING NEW FRIENDS?	Yes ? No
5.	ARE YOU INCLINED TO BE QUICK AND SURE IN YOUR ACTIONS?	Yes ? No
6.	ARE YOU FREQUENTLY "LOST IN THOUGHT" EVEN WHEN SUPPOSED TO BE TAKING PART IN A CONVERSATION?	Yes ? No
7.	ARE YOU SOMETIMES BUBBLING OVER WITH ENERGY AND SOMETIMES VERY SLUGGISH?	Yes ? No
8.	WOULD YOU RATE YOURSELF AS A LIVELY INDIVIDUAL?	Yes ? No
9.	WOULD YOU BE VERY UNHAPPY IF YOU WERE PREVENTED FROM MAKING NUMEROUS SOCIAL CONTACTS?	Yes ? No
10.	ARE YOU INCLINED TO BE MOODY?	Yes ? No
11.	DO YOU HAVE FREQUENT UPS AND DOWNS IN MOOD, EITHER WITH OR WITHOUT APPARENT CAUSE?	Yes ? No
12.	DO YOU PREFER ACTION TO PLANNING FOR ACTION?	Yes ? No
	THANK RESPONDENT AGAIN. EXPLAIN THAT YOU WOULD LIKE A FEW MORE FACTS BEFORE THE INTERVIEW IS OVER.	
	CLASSIFICATORY/	

CLASSIFICATORY DATA

7.	Sex — Male / Female	☐
8. FACTUAL QUESTION	Will you tell me how old you are? (If reluctant, show respondent age groups on CARD FOUR and tick appropriate group?)	
	CARD FOUR: 21 - 24; 25 - 29; 30 - 34; 35 - 39; 40 - 44; 45 - 49; 50 - 54; 55 - 59; 60 - 64; 65 - 69; 70 - 74; 75 - 79; 80 +	☐
	(If final refusal) Estimated Age	☐
9. FACTUAL QUESTION	Are you single or married? Divorced of widowed? — Single / Married / Separated / Divorced / Widowed	☐
10/		

10. SEE NOTES ON OCCUPATIONS

To man: Would you mind telling me your job? (Occupation, Industry and standing)

11. To woman: Would you mind telling me if you go to work?

YES

NOT WORKING

i. (If yes) What do you do? (Occupation and Industry)

Is it full-time F.T.

of part-time (less than 30 hours weekly) P.T.

ii. (If married) What does (did) your husband do? (Occupation and Industry)

iii. What does (did) your father do? (FATHER'S LAST FULL TIME OCCUPATION AND INDUSTRY)

12. Are there any children under the age of 15 in your household?

YES

NO

(If /

(If yes) Give sex and age of each:

	Sex	Age
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

13. Now, can you tell me a little about your education, please.

Primary education only ☐

Secondary education

Senior secondary ☐
Secondary modern (junior secondary) ☐
Comprehensive ☐
Other ☐

Post secondary education (specify type - University, Technical College, etc.) ☐

14./

14.	What is your religious denomination?	
14a.	Would you call yourself a regular church attender? (once a month)	☐
	an occasional attender? (less than once a month)	☐
	or don't you attend church?	☐
15.	Were you born in Edinburgh? YES If not, where were you born?	☐
15a.	Where did you spend the first ten years of your life?	
16. OPINION QUESTION	Now there is one last question I'd like to put to you. What would you say, in your own words, is the best recipe for avoiding mental illness? (Quote all respondent's words)	
	Thank you very much indeed. I hope I haven't taken up too much of your time. All that you have told me will be most helpful to us. And, of course, it will be treated as strictly confidential. When we have finished all these interviews in Edinburgh we shall have a much truer and clearer picture of how people in general feel about these mental health problems and about the best ways of helping people who have actually been mentally ill.	

Remarks:

INTERVIEW

Satisfactory

Unduly hurried

Not entirely satisfactory

Unsatisfactory

Informant alone

With others, specify:

Date of interview _____

Length of interview: From _____ to _____

Interviewer's signature: _____

APPENDIX V

MANUAL FOR INTERVIEWERS

and

SPECIMEN LETTER OF AUTHORISATION FOR INTERVIEWERS

APPENDIX V

MANUAL FOR INTERVIEWERS

MEDICAL RESEARCH COUNCIL HEALTH OPINION SURVEY

GUIDE TO INTERVIEWERS

The requirements for being a successful interviewer and survey worker are not exacting. Provided you have a friendly natural manner and can put the informant at his ease the encounter can be a satisfying experience for both of you.

Secondly, you must know the schedule and instructions thoroughly and adhere to them.

Thirdly, accurate and complete recording are essential.

THE INTERVIEW

Most people are inclined to be co-operative once their confidence is gained. The critical moment is nearly always at the very start, when an informant is surprised by the unexpected appearance of a complete stranger on their threshold. Your manner and your mode of introduction at this stage can be crucial to the success of the subsequent discussion. It is very important that you personally should expect to succeed and convey an impression of confidence.

The/

The initiative at the outset is entirely your own. The informant may take you for a travelling salesman, a bearer of unwelcome tidings or simply someone who wants to enquire the way. It is your business to set a positive tone to the subsequent proceedings by making your identity and your business clear in as few words as possible.

PROCEDURE

Having first located the correct address and made your presence known, you must ensure that you are talking to the correct person. In order that there may be no confusion on this point, mention the complete name of the person whom you wish to see. As the age of the informant will not be known to you, it is important that you should not make the mistake of interviewing a son for a father, or a mother for a daughter and vice versa.

If the informant is not at home, make a definite arrangement to call back at a suitable time, pointing out that the interview will take just under half an hour. Be sure to keep this appointment or you may sacrifice the goodwill of your respondent.

EXPLAINING WHO YOU ARE AND WHY YOU HAVE CALLED

Introduce yourself as coming on behalf of the Medical Research Council, showing your letter of authorisation.

The/

The M.R.C. are carrying out a survey, you go on to say, to find out how people in Edinburgh feel about certain health problems. (This is not the time to enter into details. The informant will be unable to grasp the finer points and may merely be confused, dismayed or discouraged by technical terms.)

However, the informant is entitled to know why they personally have been chosen. Tell them, therefore, that the M.R.C. are interviewing men and women of all ages and different occupations and that their name happens to have come up.

Follow this up by pointing out clearly that their identity will subsequently be kept confidential and that anything they care to tell you will be treated entirely anonymously.

FURTHER REASSURANCE FOR THE INFORMANT

People's reactions to your presence, even following upon your first introduction, are bound to vary, so you must be prepared to deal with any questions or reservations which they express. Some of these enquiries may be a form of playing for time on the informant's part. The time that you spend in answering them will give you a further opportunity to gain his trust and put him at ease in your presence.

For example, some people may demand more details about how they have been selected. Explain that everyone has an equal chance of being selected and it was pure chance that they were/

were chosen. You can, if necessary, mention that every nth person from a list of names of people in Edinburgh is being visited at home in order to get the views of a wide cross section of all the population.

Perhaps your initial brief account of your person and purposes has still left them in some uncertainty. They may want to be assured that they are not going to be "pestered" by any further callers or by circulars. Disclaim all association with commercial, political or other associations and stress again that this is simply a piece of research on health topics.

The informant may, quite justifiably, want to know more about what use will be made of the information, what good this proposed interview is supposed to do. You must be prepared to say with conviction how important it is to discover the opinions of ordinary people when planning how best to help people who are sick in various ways and that the only way to do this is to talk to them directly.

Some respondents, especially women or old people, may declare that they don't know anything about such things and that you had better ask someone else.

This is your opportunity to emphasise that everyone has a point of view. You don't want to test their knowledge, but their own opinion is just as important as that of any other person in the city.

Although/

Although some people may plead lack of time in order to escape the interview and may only require a little further persuasion, you must respect the fact that the informant may really be too busy to participate at the moment. Exaggerating the brevity of the interview is neither honest nor sound since, if it is begun on a wrong assumption, it may be completed with ill-will or not at all. It is much better to arrange an appointment to call again.

Occasionally, someone may declare that they don't hold with strangers poking their noses into other people's affairs. In this case, repeat that the inquiry is confidential and entirely voluntary, that most people are taking part in it and that you are hoping to get a representative cross section.

Since the views of taciturn and solitary citizens are important, do not be too easily put off, but avoid conveying the impression that you are badgering someone to answer questions against their will. This may be the moment to bid a polite good-day, remembering that not only the success of the entire survey but also the good name of its sponsor, the Medical Research Council, depend on maintaining good public relations at all times.

If the informant mistakenly fancies that your visit is directly connected with a recent experience of his own such as a stay in hospital, or some request to the Health and Welfare Department, you must correct this misapprehension. Otherwise his/

his belief that the interview was going to be on a personal matter may cause him annoyance later on and reduce the chances of success. On the other hand, he may be very unwilling to discuss personal matters, in which case you must stress that the questions are going to be general ones.

Should the informant, in spite of all explanations, completely refuse to co-operate, this refusal should be reported, along with all the relevant details.

On no account should another person be substituted for such an informant.

THE PLACE OF THE INTERVIEW

The kind of interview on which you are engaged, involving as it does sorting cards and the use of check lists, makes it very desirable, if not imperative, that it should be carried out indoors.

If the informant has not thought of asking you indoors, you will have to request his or her permission to enter, explaining that you will have some writing to do. Aim to have the informant sitting opposite you.

Always have your materials ready, watch, pen, writing board, numbered questionnaire and the various cards in their correct order. It will create a very bad impression if you have to fumble at this stage of the proceedings.

If people outside the family are present, suggest to the informant/

informant that he might prefer to talk to you in private. Although he may say he has no objection, the fact that outsiders are hearing his replies might influence his response to certain sections of the questionnaire which touch on experience of mental illness within the family.

Should others be unavoidably present during the interview, you will have to take care that the informant's responses and opinions are not being affected by them. Whilst the help of another relative or individual in recalling matters of fact is no disadvantage, it is most important that outsiders' opinions should not be recorded or be allowed to confuse those of your informant.

CONDUCT OF THE INTERVIEW

Throughout the interview you will have to sustain and build up the relationship you have established with the informant. Remarks on general topics will often help, but try to avoid allowing the informant to become too talkative or embarking upon a long discussion with you. The questionnaire has been specially designed, in its most important section, to prevent the informant's being influenced by your views. Until the interview is over you must be constantly on your guard against saying anything which may suggest what constitutes a "desirable" answer to a particular question.

Aim to carry out the interview in a businesslike manner, adjusting/

adjusting the tempo to the speed of the informant's reaction. Look directly at him when introducing topics and putting the questions.

Listen very carefully to everything that is said to you. Be very careful not to allow your initial impressions of the informant to trap you into anticipating or mistaking his subsequent responses.

The informant may mention something in the course of answering which can be used as a basis for collecting Classification Data later. For example, someone may refer to their hisband, allowing you to say in the Classification Section subsequently, "You told me you are married, didn't you?". But be on your guard against assumptions and be sure to check all facts before recording them.

PROBING AND PROMPTING

It is permissible to probe for more details on matters of fact. Thus, in the section which deals with the informant's memory of people whom he has known with mental illness, you can help by suggesting that he thinks back to earlier periods in his life, recalling family friends, aged distant relatives and so on. The same applies to programmes or articles referring to mental illness in the mass media. And other straightforward matters of fact, for example in the classification section on age, education, occupation and so on, may also require probing.

Matters/

Matters of opinions however, are very sensitive to suggestion. It is much more difficult to measure people's opinions than to collect facts about their habits and way of life. In order to reduce the influence you as an interviewer may have, even unconsciously, on your informants, a method of card sorting is being used in this survey. Opinions as stated on the cards must not be paraphrased in any way. They can be read out, exactly as they stand, if the informant cannot decipher them. You must point out, if he asks the meaning, that you simple want his reaction to the given statement, how it appears to him.

The opinion sections of this schedule are clearly marked (Nos. 1, 5, 6 and 16) so that they are immediately recognisable.

Each of these questions must be asked exactly as it appears on the schedule. This is absolutely essential in questions of opinion as slight alterations in wording can alter a question's implications and suggest what reply is expected.

All the questions must be asked in the order specified, since the informants' replies might be influenced by the order in which the questions are posed. Moreover, only in this way, can you be sure of completing the entire schedule without missing out any sections.

RECORDING/

RECORDING REPLIES

The schedule is so arranged that most of the replies are to be recorded, with scrupulous accuracy, at the time they are given. You will need to have a very thorough knowledge of the schedule, so as to be able to concentrate on what the informant is saying and get the exact meaning of each reply.

There are, however, two sections of this schedule which require a special method of scoring:

Scoring of Section 5

The first of these is Section 5, which involves the sorting by you of 47 cards, bearing attitude and opinion statements, into five marked boxes.

When the sorting has been completed you must file the cards from each box into the five appropriately marked and numbered envelopes which accompany each schedule.

These envelopes should then be pinned together onto the schedule to which they relate.

Later in the day you must make an opportunity to examine the cards from each of the envelopes in turn and enter the corresponding scores, by means of ticks (✓) into the columns of the score sheet.

After you have completed the scoring for a schedule, re-arrange the cards in numerical order so that the pack will be ready for use in a subsequent interview.

The/

The scoring of Section 5 is vital, and it is advisable not to reshuffle an individual pack of cards until you have completed the scoring, in case of the need for rechecking the contents of any particular envelope.

Scoring of Section 6

Section 6 is not scored by you at all, but is the responsibility of your informant.

Make sure he or she understands what is required of him by giving the instructions slowly and clearly and repeating if necessary.

The informant then puts a circle round the word ("Yes", "?", or "No") which corresponds to their own reactions to each of the 12 questions.

You will notice that both these sections deal with the informant's opinions. They have in fact been specially designed so that the informant can quietly concentrate on answering them without any intervention on your part. That is why Section 5 needs to be scored later and why Section 6 is scored by the informant.

CLASSIFICATORY DATA

The sex of your informant should not be in doubt.

Age

Ask directly about age and, if the informant is reluctant,

show/

show them the card bearing age groups. If they still hesitate, you will have to make your own estimate of their age group, which you will insert unobtrusively or after leaving.

Marital Status

Find out the exact marital status of your informant. This information is easy to obtain on the spot but impossible to infer later.

Occupation

Details of occupation must be obtained from all men regarding themselves. In the case of women details of their own occupation, if any, must also be obtained.

But in addition we want to know about the father's occupation in the case of both single and married women. And also the occupation of the husband of a married woman.

The father's last full time occupation is the one which matters.

If the male informant or a woman's husband has retired from his job with a pension, he should be described as 'retired policeman', 'retired schoolmaster', 'retired railway porter', etc., whether or not he also gets the O.A.P.

A retired person having no pension except the O.A.P. should be described as O.A. Pensioner only.

If your informant is not a worker, give an indication of his or her activities or position, e.g. housewife, student, bank/

bank-manager's widow, etc. When in doubt, always err on the side of giving too much, rather than too little information.

As an appendix to this guide some notes on occupation are given. These will give an indication of the type of detail required.

Education

The section on education allows for primary education only, several different forms of secondary education and post secondary education. The latter must be specified in full for coding later.

Church Attendance

Be careful in your approach to the subject of church attendance as some people may be sensitive about their frequency of attendance.

Place of Birth

We are anxious to find out exactly where people were born and lived and spent their first ten years, as during this time some of their attitudes were being formed. So enter all the details.

APPENDIX TO INTERVIEWERS MANUAL ON OCCUPATION

Inadequate Description	Required Detail
Clerk	'Clerk' is too vague. State whether he is a bank clerk, railway clerk, Town Clerk, etc.
Engineer	This can range from a man with a University, or other, degree to a manual worker. If a qualified engineer, state branch of engineering: otherwise give trade or type of job, e.g. fitter, toolmaker, etc.
Civil Servant	'Civil Servant' covers a range of occupations in manual (e.g. postmen), clerical (e.g. junior, higher, senior, chief executive officer) and administrative classes (e.g. assistant principal, principal, assistant secretary), apart from specialist or departmental classes such as lawyers, scientists, doctors or tax inspectors, factory inspectors, customs officers. Workers in Government factories too may sometimes be described as civil servants. Give full details of rank and type of work done. This also applies to local Government.

Builder/

Builder	This could range from the owner of a large contracting business to a bricklayer's assistant. If your informant owns a business, indicate this, and give approximate size. In other cases, give details of the trade, carpenter, bricklayer, builder's labourer, etc.
Farmer	Give details of size and type of farm, number and types of employees if informant is an employer, or job, e.g. farm labourer if informant is employee.
Own Business, e.g. Building Contractor, Haulage Contractor, etc.	Describe type of business and give number of employees.
Miner	State whether coal mine or other type of mine; also whether informant works above or below ground. Give further particulars of work and position.
Shop Owner	This covers a wide range of social grades, depending on the size of the business. State the number of assistants, size and type of shop(s).

Shop Assistant/

Shop Assistant	Give details of any special training, responsibility and seniority, and type of shop.
Foreman	State whether mainly manual or non-manual.
Inspector	State exactly what he 'inspects' and degree of responsibility.
Manager	State size of department or shop, type of business and number of staff controlled.
Representative or Commercial Traveller	State seniority, kind of organisation worked for, nature of work and area covered.
Insurance Official	State work, size of department, if any, type of responsibility.
Accountant	State qualifications and responsibility, also whether employer or employee.
Headmaster or Mistress	State size and type of school.
Schoolteacher	State whether senior or junior; e.g. under or over 30 years of age, whether where are special responsibilities and/or subjects: size and type of school.

Company/

Company Director Company Secretary	Size and type of firm.
Lorry Driver	State whether long or short distance.
Security Officer	State degree of responsibility; e.g. whole factory with number of employees, only responsible for factory gate, etc.
Retired Person	A person who has retired from his job with a pension should be described as 'retired policeman', 'retired schoolmaster', 'retired railway porter', etc., whether or not he also gets the O.A.P. A retired person having no pension except the O.A.P. should be described as <u>O.A. Pensioner only</u>.

If your informant is not a worker, give an indication of his or her activities or position, e.g. housewife, student, bank manager's widow, etc. <u>When in doubt, always err on the side of giving too much</u>, rather than too little information.

STANDARD ABBREVIATIONS

H/W	Housewife
H/H	Head of household
C.W.E.	Chief Wage Earner
D.K.	Don't know
IR	Information refused
D.N.A.	Does not apply
O.A.P.	Old Age Pensioner
Wid. P.	Widow's Pension
Ret.	Retired
Unoc.	Unoccupied
F/T	Full time
P/T	Part time
F/S	Fully skilled
S/S	Semi skilled
U/S	Unskilled
S/E	Self employed
O/Bus.	Own business
Man.	Manual
Non Man.	Non Manual

APPENDIX V

SPECIMEN LETTER OF AUTHORISATION FOR INTERVIEWERS

MEDICAL RESEARCH COUNCIL

UNIT FOR RESEARCH ON THE EPIDEMIOLOGY OF PSYCHIATRIC ILLNESS

Edinburgh University Department
of Psychiatry,
Royal Edinburgh Hospital,
Morningside Park,
EDINBURGH, 10.

Telephone:
Morningside 7489

Dear Sir/Madam,

The bearer, Mrs. X, is employed by the Medical Research Council in connection with the Department of Psychological Medicine of the University of Edinburgh and I should be most grateful for any help that you may be able to give her.

Yours faithfully,

(Signed) CATHERINE M.U. MACLEAN

Catherine M.U. Maclean, M.D., D.P.H.

APPENDIX VI

THE RESULTS OF THE EDINBURGH SURVEY

Sections 1 to 7

(To be consulted in relation to Chapter VII of text)

APPENDIX VI

THE RESULTS OF THE EDINBURGH SURVEY

SECTION 1

The Sample

Table 1

Reasons for failure to interview

Category	No.
Refusal by respondent	28
Refusal by another on respondent's behalf	4
Always out*, failed to keep appointment	21
Removed	44
Dead	5
Ill	10
Old and infirm	8
On holiday*	5
Foreign (Language problem)	2

(* After three or more calls back)

Table 2

Reduction of the initial sample; success and refusal rates

Initial sample size	500
Persons not available for interview	54
Total interviewed	373

Success rate = 83.6 per cent of available respondents

Refusals/

Refusals by available members of sample 32

Refusal rate = 7.4 per cent of available respondents

Persons not contacted for other reasons 41

= 10.9 per cent of available respondents

SECTION 2

Comparison of Sample with Census

Table 3

Age distribution of adult males in 1966 sample and 1961 Census

	Sample		Census	
Age group	No.	Per cent	No.	Per cent
20-24*	7	4.2	15,173	10.3
25-29	11	6.6	14,150	9.9
30-34	11	6.6	13,927	9.5
35-39	21	12.6	14,763	10.1
40-44	20	11.9	13,321	9.1
45-49	16	9.6	14,756	10.0
50-54	16	9.6	15,583	10.6
55-59	26	15.6	14,074	9.6
60-64	15	8.9	10,628	7.2
65-69	13	7.8	7,907	5.4
70-74	3	1.8	5,625	3.8
75 +	8	4.8	6,433	4.4
Totals	167		146,750	

(* 21-24 for sample)

Table 4/

Table 4

Age distribution of adult females in 1966 sample and 1961 Census

Age group	Sample		Census	
	No.	Per cent	No.	Per cent
20-24*	12	5.8	17,081	9.3
25-29	26	12.6	14,601	8.0
30-34	24	11.6	14,816	8.1
35-39	15	7.2	15,785	8.6
40-44	25	12.1	15,248	8.3
45-49	23	11.2	17,470	9.6
50-54	15	7.3	18,213	9.9
55-59	21	10.2	17,284	9.5
60-64	15	7.3	15,161	8.3
65-69	10	4.8	12,825	7.0
70-74	10	4.8	10,320	5.6
75 +	10	4.8	13,782	7.5
Totals	206		182,586	

(* 21-24 for sample)

SECTION 3

Further characteristics of the sample

Table 5

Marital state of 373 respondents

State	No.	Per cent
Single	45	12.1
Married	284	76.1
Separated	7	1.9
Divorced	5	1.3
Widowed	31	8.3
No answer	1	0.3

Table 6/

Table 6

Social Class, men

(Total replying = 163)

Social Class	No.	Per Cent
I	2	1.2
II	20	12.3
III	89	54.6
IV	25	15.4
V	27	16.6

Table 7

Social Class of employed women

(Total reporting own employment = 102)

Social Class	No.	Per Cent
I	1	1.0
II	5	4.9
III	34	33.3
IV	30	29.4
V	28	27.4
Retired	2	2.0
Unclassified	2	2.0

Table 8

Social class of married women
according to husband's occupation

(Total reporting husband's occupation = 172)

Social Class	No.	Per Cent
I	3	1.7
II	21	12.2
III	93	54.1
IV	35	20.3
V	20	11.6

Table 9/

Table 9

Educational level of respondents

(N = 373)

Category	No.	Per cent
Primary only, or left school at 14	130	34.8
Secondary modern	146	39.1
Junior secondary	10	2.7
Senior secondary	57	15.3
Comprehensive	7	1.9
University	5	1.3
Technical College	4	1.9
Training College	8	2.1
Post secondary evening classes	1	0.3
Other	3	0.8
No reply	2	0.5

Table 10

Percentage of respondents in main educational categories

Primary education only	34.8%	76.6%
Secondary modern	41.8%	
Senior Secondary	15.3%	
Post Secondary	5.6%	
Other	2.5%	

Table 11/

Table 11

Respondents' Personal Experience of the Mentally Ill

Self	24
Mother	9
Father	4
Spouse	6
Sibling	11
Child	3
Other Relative	33
Friend	38
Acquaintance	36
Workmate or person met at work	41
Unclassified	2
No experience	166

Table 12

Summary of Respondents' Personal Experience of the Mentally Ill

Category of Experience	No.	Per cent
Some Experience	205	54.9
No Experience (includes unclassified)	168	45.0
Experience of more than one person	75	20.1
Self once mentally ill	24	6.4

Table 13

Respondents' Reported Experience of Visiting Mental Hospitals

(N = 373)

	No.	Per cent
Total who had visited	152	40.7
Total who had never visited	221	59.2
Total who had visited more than one hospital	12	3.2

Table 14/

Table 14

Site of Mental Hospital Visited by 152 Respondents

Site	Site	Per cent
Edinburgh (including Bangour)	115	75.7
Elsewhere in Scotland	22	
Beyond Scotland	15	

Table 15

Date of Visit to Mental Hospitals as recalled by 147 Respondents

Period	No.	Per cent
1-4 years previously	58	58.5
5-9 years previously	28	
10-14 years previously	20	
15-19 years previously	9	
20 + years previously	32	

Table 16

Respondents' information regarding mental illness acquired during 3 months prior to interview

Information source	No.		Per cent
T.V.	148		
Radio	7		
Talk or lecture	2	220	59.0
Newspaper or magazine	31		
Film	3		
Conversation	29		
No recent information	153		41.0

Table 17/

Table 17

Source of recent information of mental illness cited by 220* respondents

Source	No.	Per cent
T.V.	148	67.2
Radio	7	3.2
Newsprint	31	14.1
Film	3	1.4
Talk or lecture	2	1.0
Conversation	29	13.2

(* Among these were 62 people who reported on more than one recent information source on mental illness.)

Table 18

Respondents' Religious Denomination and Observance

Protestant	Regular*	70
	Occasional+	125
Catholic	Regular	28
	Occasional	14
Never attends church		122
No religion		11
No reply		3

(* Regular: once a month or more)
(+ Occasional: less than once a month)

Table 19

Respondents' scores on N scale of M.P.I. (N=372*)

No.	Score
54	0
5	1
43	2
6	3

57/

Table 19 (continued)

Respondents' scores on N scale of M.P.I. (N=372*) (Continued)

No.	Score
57	4
7	5
63	6
6	7
50	8
1	9
41	10
6	11
33	12
1	No reply

Mean score 5.57

Standard deviation 3.74

(* One respondent did not reply)

Table 20

Distribution of neuroticism scores

Score	Persons	Percentage of Population
0 - 1	59	15.9
2 - 3	49	13.2
4 - 5	64	17.2
6 - 7	69	18.5
8 - 9	51	13.7
10 - 11	47	12.6
12	33	8.9

Table 21/

Table 21

Respondents' scores on E Scale of M.P.I.

(N = 372*)

No.	Score
11	0
4	1
27	2
6	3
49	4
10	5
54	6
18	7
75	8
13	9
68	10
6	11
31	12

(* One respondent did not reply)

Table 22

Distribution of extraversion scores

Score	Persons	Percentage of Population
0 - 1	15	4.0
2 - 3	33	8.9
4 - 5	59	15.9
6 - 7	72	19.3
8 - 9	88	23.6
10 - 11	74	19.9
12	31	8.3

SECTION 4/

SECTION 4

Qualitative data relating to attitudes and opinions regarding mental health

47 Statements of Attitude and Opinion regarding Mental Illness and the Mentally Ill.

Table 23

Statement 1 - The mentally ill are dangerous. (N = 373)

Response	No.	Per cent	
Strongly agree	22	5.9	33.5
Agree	103	27.6	
No opinion	59	15.8	
Disagree	167	44.8	50.7
Strongly disagree5	22	5.9	

Table 24

Statement 2 - The mentally ill should be put away in institutions. (N = 373)

Response	No.	Per cent	
Strongly agree	19	5.1	43.2
Agree	142	38.1	
No opinion	47	12.6	
Disagree	132	35.4	44.2
Strongly disagree	33	8.8	

Table 25

Statement 3 - People who have become mentally ill are to be pitied. (N = 373)

Response	No.	Per cent	
Strongly agree	56	15.0	71.8
Agree	212	56.8	
No opinion	18	4.8	
Disagree	67	17.9	23.3
Strongly disagree	20	5.4	

Table 26/

Table 26

Statement 4 - Close association with people who are mentally ill is liable to make a normal person break down. (N = 373)

Response	No.	Per cent	
Strongly agree	19	5.1	41.0
Agree	134	35.9	
No opinion	38	10.2	
Disagree	145	38.9	48.8
Strongly disagree	37	9.9	

Table 27

Statement 5 - Mental illness is something it is best not to talk about. (N = 373)

Response	No.	Per cent	
Strongly agree	13	3.5	24.7
Agree	79	21.2	
No opinion	18	4.8	
Disagree	164	44.0	70.5
Strongly disagree	99	26.5	

Table 28

Statement 6 - Most women who were once patients in a mental hospital could be trusted as baby-sitters. (N = 373)

Response	No.	Per cent	
Strongly agree	9	2.4	26.3
Agree	89	23.9	
No opinion	95	25.5	
Disagree	154	41.3	48.3
Strongly disagree	26	7.0	

Table 29/

Table 29

Statement 7 - As soon as someone begins to show signs of mental disturbance they should receive hospital treatment. (N = 373)

Response	No.	Per cent	
Strongly agree	105	28.1	93.8
Agree	245	65.7	
No opinion	10	2.7	
Disagree	9	2.4	3.5
Strongly disagree	4	1.1	

Table 30

Statement 8 - Mentally ill people seem to live in a different world to the rest of us. (N = 373)

Response	No.	Per cent	
Strongly agree	30	8.0	70.7
Agree	234	62.7	
No opinion	56	15.0	
Disagree	49	13.1	14.2
Strongly disagree	4	1.1	

Table 31

Statement 9 - Most patients in mental hospitals have to be kept there against their will. (N = 373)

Response	No.	Per cent	
Strongly agree	14	3.7	35.1
Agree	117	31.4	
No opinion	67	18.0	
Disagree	149	39.9	46.9
Strongly disagree	26	7.0	

Table 32/

Table 32

Statement 10 - Sometimes it's difficult to think of the mentally ill as ordinary human beings. (N = 373)

Response	No.	Per cent	
Strongly agree	10	2.7	28.2
Agree	99	25.5	
No opinion	42	11.3	
Disagree	177	47.4	59.5
Strongly disagree	45	12.1	

Table 33

Statement 11 - I would be willing for a member of my family to marry someone who had once been a mental hospital patient. (N = 373)

Response	No.	Per cent	
Strongly agree	10	2.7	20.9
Agree	68	18.2	
No opinion	89	23.9	
Disagree	158	42.4	55.3
Strongly disagree	48	12.9	

Table 34

Statement 12 - Mentally ill people are ruled more by their emotions than normal people are. (N = 373)

Response	No.	Per cent	
Strongly agree	22	5.9	75.1
Agree	258	69.2	
No opinion	66	17.7	
Disagree	24	6.4	7.2
Strongly disagree	3	0.8	

Table 35/

Table 35

Statement 13 - People who are mentally ill ought not to be allowed to mix with ordinary people. (N = 373)

Response	No.	Per cent	
Strongly agree	9	2.4	18.2
Agree	59	15.8	
No opinion	23	6.2	
Disagree	208	55.8	75.6
Strongly disagree	74	19.8	

Table 36

Statement 14 - What the mentally ill need more than anything else is to have people show them sympathy. (N = 373)

Response	No.	Per cent	
Strongly agree	52	13.9	55.8
Agree	156	41.8	
No opinion	34	9.1	
Disagree	118	31.6	35.1
Strongly disagree	13	3.5	

Table 37

Statement 15 - A former mental patient could be trusted in a responsible position, as a lawyer, for example. (N = 372)

Response	No.	Per cent	
Strongly agree	11	3.0	38.7
Agree	133	35.7	
No opinion	96	25.7	
Disagree	109	29.2	35.4
Strongly disagree	23	6.2	

Table 38/

Table 38

Statement 16 - Rest won't prevent mental disorders. (N = 373)

Response	No.	Per cent	
Strongly agree	17	4.6	46.2
Agree	155	41.6	
No opinion	85	22.8	
Disagree	105	28.1	31.1
Strongly disagree	11	2.9	

Table 39

Statement 17 - It is generally accidents or illness that brings on mental illness. (N = 373)

Response	No.	Per cent	
Strongly agree	13	3.5	37.0
Agree	125	33.5	
No opinion	80	21.4	
Disagree	131	35.1	41.5
Strongly disagree	24	6.4	

Table 40

Statement 18 - Drink is one of the main causes of mental illness. (N = 373)

Response	No.	Per cent	
Strongly agree	20	5.4	30.3
Agree	93	24.9	
No opinion	63	6.9	
Disagree	163	43.7	52.8
Strongly disagree	34	9.1	

Table 41/

Table 41

Statement 19 - An unhappy home life is one of the main causes of mental illness. (N = 373)

Response	No.	Per cent	
Strongly agree	34	9.1	65.4
Agree	210	56.3	
No opinion	46	12.3	
Disagree	75	20.1	22.2
Strongly disagree	8	2.1	

Table 42

Statement 20 - Much mental illness is the result of the stress and strain of present day living. (N = 373)

Response	No.	Per cent	
Strongly agree	66	17.7	80.2
Agree	233	62.5	
No opinion	25	6.7	
Disagree	47	12.6	13.1
Strongly disagree	2	0.5	

Table 43

Statement 21 - A change of climate seldom helps a developing mental illness. (N = 373)

Response	No.	Per cent	
Strongly agree	14	3.75	41.8
Agree	142	38.07	
No opinion	137	36.7	
Disagree	76	20.4	21.4
Strongly disagree	4	1.0	

Table 44/

Table 44

Statement 22 - Job worries can bring on mental illness. (N = 372)

Response	No.	Per cent	
Strongly agree	54	14.5	88.7
Agree	276	74.2	
No opinion	16	4.3	
Disagree	22	5.9	7.0
Strongly disagree	4	1.1	

Table 45

Statement 23 - Overwork is a big cause of mental illness. (N = 373)

Response	No.	Per cent	
Strongly agree	45	12.1	81.5
Agree	259	69.4	
No opinion	19	5.1	
Disagree	47	12.6	13.4
Strongly disagree	3	0.8	

Table 46

Statement 24 - Children who are made to feel they are not wanted develop a mental illness when they grow up. (N = 373)

Response	No.	Per cent	
Strongly agree	38	10.2	69.7
Agree	222	59.8	
No opinion	54	14.4	
Disagree	52	13.9	15.8
Strongly disagree	7	1.9	

Table 47/

Table 47

Statement 25 - Mental illness can be avoided by avoiding gloomy thoughts. (N = 373)

Response	No.	Per cent	
Strongly agree	16	4.3	38.9
Agree	129	34.6	
No opinion	93	24.9	
Disagree	119	31.9	36.2
Strongly disagree	16	4.3	

Table 48

Statement 26 - Money worries are a big cause of mental illness. (N = 373)

Response	No.	Per cent	
Strongly agree	56	15.0	74.0
Agree	220	59.0	
No opinion	32	8.6	
Disagree	61	16.3	17.4
Strongly disagree	4	1.1	

Table 49

Statement 27 - One of the main causes of mental illness is lack of moral strength. (N = 373)

Response	No.	Per cent	
Strongly agree	19	5.1	41.8
Agree	137	36.7	
No opinion	79	21.2	
Disagree	122	32.7	37.0
Strongly disagree	16	4.3	

Table 50/

Table 50

Statement 28 - Sexual overindulgence will end for some people in mental illness. (N = 373)

Response	No.	Per cent	
Strongly agree	27	7.2	38.3
Agree	116	31.1	
No opinion	144	38.6	
Disagree	78	20.9	23.0
Strongly disagree	8	2.1	

Table 51

Statement 29 - Mental patients usually settle back into ordinary life again quite easily when they are discharged from hospital. (N = 373)

Response	No.	Per cent	
Strongly agree	17	4.6	52.3
Agree	178	47.7	
No opinion	85	22.8	
Disagree	88	23.6	24.9
Strongly disagree	5	1.3	

Table 52

Statement 30 - Mental illness can often be helped by a holiday or change of scene. (N = 373)

Response	No.	Per cent	
Strongly agree	19	5.1	71.6
Agree	248	66.5	
No opinion	53	14.2	
Disagree	51	3.7	4.2
Strongly disagree	2	0.5	

Table 53/

Table 53

Statement 31 - To develop a mental illness is one of the worst things that could happen to anyone. (N = 373)

Response	No.	Per cent	
Strongly agree	75	20.1	71.6
Agree	192	51.5	
No opinion	21	5.6	
Disagree	70	18.8	22.8
Strongly disagree	15	4.0	

Table 54

Statement 32 - Few people who enter a mental hospital ever leave it. (N = 373)

Response	No.	Per cent	
Strongly agree	5	1.3	12.8
Agree	43	11.5	
No opinion	54	14.5	
Disagree	200	53.6	72.6
Strongly disagree	71	19.0	

Table 55

Statement 33 - Many of the mentally ill people who seem to be better will be back for more treatment later on. (N = 373)

Response	No.	Per cent	
Strongly agree	9	2.4	56.5
Agree	202	54.1	
No opinion	92	24.7	
Disagree	61	16.3	18.7
Strongly disagree	9	2.4	

Table 56/

Table 56

Statement 34 - I would be willing to have a former mental patient live next door. (N = 373)

Response	No.	Per cent	
Strongly agree	18	4.8	64.0
Agree	221	59.2	
No opinion	71	19.0	
Disagree	53	14.2	16.9
Strongly disagree	10	2.7	

Table 57

Statement 35 - The eyes of the mentally ill are glassy. (N = 373)

Response	No.	Per cent	
Strongly agree	6	1.6	18.2
Agree	62	16.6	
No opinion	205	55.0	
Disagree	79	21.2	26.8
Strongly disagree	21	5.6	

Table 58

Statement 36 - When a person becomes mentally ill it's just like losing them altogether. (N = 373)

Response	No.	Per cent	
Strongly agree	19	5.1	41.0
Agree	134	35.9	
No opinion	50	13.4	
Disagree	142	38.1	45.6
Strongly disagree	28	7.5	

Table 59/

Table 59

Statement 37 - I would be willing to work in a job alongside a former mental patient. (N = 373)

Response	No.	Per cent	
Strongly agree	28	7.5	76.7
Agree	258	69.2	
No opinion	41	11.0	
Disagree	40	10.7	12.3
Strongly disagree	6	1.6	

Table 60

Statement 38 - People who are mentally ill are liable to commit suicide. (N = 372)

Response	No.	Per cent	
Strongly agree	27	7.2	59.9
Agree	196	52.7	
No opinion	75	20.2	
Disagree	65	17.5	19.4
Strongly disagree	7	1.9	

Table 61

Statement 39 - The mentally ill don't care about their personal appearance. (N = 373)

Response	No.	Per cent	
Strongly agree	17	4.6	42.4
Agree	141	37.8	
No opinion	80	21.4	
Disagree	126	33.8	36.2
Strongly disagree	9	2.4	

Table 62/

Table 62

Statement 40 - I would let a former mental patient teach my children. (N = 373)

Response	No.	Per cent	
Strongly agree	5	1.3	25.4
Agree	127	24.0	
No opinion	102	27.3	
Disagree	117	31.4	37.3
Strongly disagree	22	5.9	

Table 63

Statement 41 - The mentally ill are unreliable, you never know what they will do next. (N = 373)

Response	No.	Per cent	
Strongly agree	17	4.6	57.1
Agree	196	52.5	
No opinion	77	20.6	
Disagree	72	19.3	22.2
Strongly disagree	11	2.9	

Table 64

Statement 42 - People nowadays are sufficiently tolerant towards the mentally ill. (N = 373)

Response	No.	Per cent	
Strongly agree	20	5.4	60.4
Agree	205	55.0	
No opinion	31	8.3	
Disagree	102	27.4	31.2
Strongly disagree	14	3.8	

Table 65/

Table 65

Statement 43 - Most people in mental hospitals nowadays have gone in of their own free will. (N = 373)

Response	No.	Per cent	
Strongly agree	13	3.5	60.3
Agree	212	56.8	
No opinion	98	26.3	
Disagree	43	11.5	13.4
Strongly disagree	7	1.9	

Table 66

Statement 44 - Women at the change of life are very liable to become mentally ill. (N = 373)

Response	No.	Per cent	
Strongly agree	22	5.9	65.1
Agree	221	59.2	
No opinion	84	22.5	
Disagree	43	11.5	12.3
Strongly disagree	3	0.8	

Table 67

Statement 45 - A district nurse who had once been a mental patient could return to her job afterwards. (N = 373)

Response	No.	Per cent	
Strongly agree	9	2.4	50.1
Agree	178	47.7	
No opinion	96	25.7	
Disagree	81	21.7	24.1
Strongly disagree	9	2.4	

Table 68/

Table 68

Statement 46 - Sexual self abuse may cause some people to become mentally ill. (N = 372)

Response	No.	Per cent	
Strongly agree	5	1.3	14.7
Agree	50	13.4	
No opinion	139	37.3	
Disagree	158	42.5	48.0
Strongly disagree	20	5.5	

Table 69

Statement 47 - I think that in general people should be expected to handle their own problems. (N = 373)

Response	No.	Per cent	
Strongly agree	32	8.6	59.3
Agree	189	50.7	
No opinion	31	8.3	
Disagree	102	27.3	32.4
Strongly disagree	19	5.1	

SECTION 5

Table 70

Consensus of Scottish Psychiatric Opinion
(over 90 per cent agreement)

Statement 16 - "Rest won't prevent mental disorders" - agree

Statement 17 - "It is generally accidents of illness that bring on mental illness" - disagree

Statement 18 - "A change of climate seldom helps a developing mental illness" - agree

Statement/

Statement 23 - "Overwork is a big cause of mental illness" - disagree.

Statement 24 - "Children who are made to feel they are not wanted may develop a mental illness when they grow up" - agree.

Statement 25 - "Mental illness can be avoided by avoiding gloomy thoughts" - disagree.

Statement 27 - "One of the main causes of mental illness is lack of moral strength" - disagree.

Statement 28 - "Sexual over-indulgence will end for some people in mental illness"- disagree.

Statement 30 - "Mental illness can often be helped by holiday or change of scene" - disagree.

Statement 32 - "Few people who enter a mental hospital ever leave it" - disagree.

Table 71

Majority Agreement among Psychiatrists (over 50%)

Statement 18 - "Drink is one of the main causes of mental illness" - (58% disagree).

Statement 20 - "Much mental illness is the result of the strain and stress of present day living - (66.6% disagree).

Statement 22 - "Job worries can bring on mental illness" - (58.3% agree).

Statement 26 - "Money worries are a big cause of mental illness" - (75% disagree).

Statement 33 - "Many of the mentally ill people who seem to be better will be back for more treatment later on" - (66.6% disagree).

Table 72/

Table 72

The comparison between public and psychiatric opinion

Comparison of psychiatric and public opinion		Psychiatrists		Public	
		% Agree	% Disagree	% Agree	% Disagree
Statement					
16	Rest won't prevent mental disorders	100	0	46	31
17	It is generally accidents or illness that bring on mental illness.	0	100	37	42
18	Drink is one of the main causes of mental illness	42	58	30	53
20	Much mental illness is the result of the strain and stress of present day living	17	67	80	13
21	A change of climate seldom helps a developing mental illness	92	8	41	21
22	Job worries can bring on mental illness	58	25	88	7
23	Overwork is a big cause of mental illness	0	92	81	13
24	Children who are made to feel they are not wanted may develop mental illness when they grow up	92	0	70	16
25	Mental illness can be avoided by avoiding gloomy thoughts	0	100	39	36
26	Money worries are a big cause of mental illness	0	75	74	17

27/

Comparison of psychiatric and public opinion		Psychiatrists		Public	
		% Agree	% Disagree	% Agree	% Disagree
27	One of the main causes of mental illness is lack of moral strength	0	92	42	35
28	Sexual over-indulgence will end for some people in mental illness	0	92	38	23
29	Mental patients usually settle back into ordinary life again quite easily when they are discharged from hospital	50	41	52	25
30	Mental illness can often be helped by a holiday or change of scene	8	92	72	4
31	To develop a mental illness is one of the worst things that could happen to anyone	33	50	72	23
32	Few people who enter a mental hospital ever leave it	0	100	13	73
33	Many of the mentally ill people who seem to be better will be back for more treatment later on	25	67	57	19

SECTION 6

The relationship between responses to specific opinion/attitude statements and certain characteristics of the respondents[1]

Table/

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1 In some instances the total figure for the number of respondents is less than 373 because of a few persons not being classifiable in the precise categories under consideration.

Table 73

Experience of the mentally ill in relation to reactions to the statement No. 1: "The mentally ill are dangerous" (N = 373)

Statement 1

	Agree	No opinion	Disagree
Experience	68	29	108
No experience	57	30	81

Chi-square = 1.18
d.f. = 2
$.5 < p < .70$
not significant

Table 74

Experience of the mentally ill in relation to reactions to the statement No. 7: "As soon as someone begins to show signs of mental disturbance they should receive hospital treatment" (N = 373)

Statement 7

	Agree	No opinion	Disagree
Experience	189	5	11
No experience	161	5	2

Chi-square = 3.59
d.f. = 2
$.10 < p < .20$
not significant

Table 75/

Table 75

Experience of the mentally ill in relation to reactions to the statement No. 32: "Few people who enter a mental hospital ever leave it" (N = 373)

Statement 32

	Agree	No opinion	Disagree
Experience	25	24	156
No experience	23	30	115

Chi-aquare = 2.71
d.f. = 2
.20 < p < .30
not significant

Table 77

Experience of the mentally ill in relation to reactions to the statement No. 9: "Most patients in mental hospitals still have to be kept there against their will" (N = 373)

Statement 9

	Agree	No opinion	Disagree
Experience	68	30	107
No experience	63	37	68

Chi-square = 5.24
d.f. = 2
.05 < p < .10
not significant (but nearly so)

Table 78/

Table 78

Experience of the mentally ill in relation to reactions to the statement No. 41: "The mentally ill are unreliable, you never know what they will do next" (N = 373)

Statement 41

	Agree	No opinion	Disagree
Experience	122	37	46
No experience	91	40	37

Chi-square = 1.99
d.f. = 2
$.30 < p < .50$
not significant

Table 79

Age in relation to reactions to the statement No. 1: "The mentally ill are dangerous" (N = 373)

Statement 1

	Agree	No opinion	Disagree
21-29	13	8	35
30-49	41	29	85
50 +	71	22	69

Chi-square = 13.16
d.f. = 4
$.01 < p < .02$
significant

Table 80/

Table 80

Age in relation to reactions to the statement No. 5: "Mental illness is something it's best not to talk about" (N =373)

Statement 5

	Agree	No opinion	Disagree
21-49	27	5	179
50+	65	13	84

Chi-square = 47.96
d.f. = 2
$p < .005$
Highly significant

Table 81

Age in relation to reactions to the statement No. 28: "Sexual over-indulgence will end for some people in mental illness" (N = 373)

Statement 28

	Agree	No opinion	Disagree
21-29	13	22	21
30-49	58	57	40
50+	72	65	25

Chi-square = 14.75
d.f. = 4
$.001 < p < .01$
significant

Table 82/

Table 82

Age in relation to reactions to the statement No. 41: "The mentally ill are unreliable, you never know what they will do next" (N = 373)

Statement 41

	Agree	No opinion	Disagree
20-29	28	18	10
30-49	80	29	46
50+	105	30	27

Chi-square = 12.01
d.f. = 4
$.01 < p < .02$
significant

Table 83

Sex in relation to reactions to the statement No. 1: "The mentally ill are dangerous" (N =373)

Statement 1

	Agree	No opinion	Disagree
Male	62	22	83
Female	63	37	106

Chi-square = 2.06
d.f. = 2
$.30 < p < .40$
not significant

Table 84/

Table 84

Sex in relation to reactions to the statement No. 5: "Mental illness is something it's best not to talk about" (N = 373)

Statement 5

	Agree	No opinion	Disagree
Male	54	4	109
Female	38	14	154

Chi-square = 10.55
d.f. = 2
$p < .005$
Highly significant

Table 85

Sex in relation to reactions to the statement No. 28: "Sexual over-indulgence will end for some people in mental illness" (N = 373)

Statement 28

	Agree	No opinion	Disagree
Male	79	50	38
Female	64	94	48

Chi-square = 11.40
d.f. = 2
$.001 < p < .005$
Highly significant

Table 86/

Table 86

Sex in relation to reactions to the statement No. 40: "I would let a former mental patient teach my children" (N = 373)

Statement 40

	Agree	No opinion	Disagree
Male	61	42	64
Female	78	60	68

Chi-square = 1.01
d.f. = 2
$.60 < p < .70$
Not significant

Table 87

Sex in relation to reactions to the statement No. 6: "Most women who were once patients in a mental hospital could be trusted as baby sitters" (N = 373)

Statement 6

	Agree	No opinion	Disagree
Male	46	42	79
Female	52	53	101

Chi-square =.1355
d.f. = 2
$.90 < p < .95$
not significant

Table 88/

Table 88

Recent information in relation to reactions to the statement No. 5: "Mental illness is something it's best not to talk about" (N =373)

Statement 5

	Agree	No opinion	Disagree
No recent information	43	11	99
Recent information	49	9	164

Chi-square = 4.35
d.f. = 2
$.10 < p < .20$
not significant

Table 89

Recent information in relation to reactions to the statement No. 43: "Most people in mental hospitals nowadays have gone in of their own free will" (N =373)

Statement 43

	Agree	No opinion	Disagree
No information	81	46	26
Information	144	52	24

Chi-square = 5.99
d.f. = 2
$.05 < p < .10$
not significant (but almost so)

Table 90/

Table 90

Recent information in relation to reactions to the statement No. 9: "Most patients in mental hospitals still have to be kept there against their will" (N = 373)

Statement 9

	Agree	No opinion	Disagree
No information	52	33	68
Some information	79	34	107

Chi-square = 1.86
d.f. = 2
$.30 < p < .50$
not significant

Table 91

Educational level in relation to reactions to the statement No. 5: "Mental illness is something it's best not to talk about" (N = 368)*

Statement 5

	Agree	No opinion	Disagree
Primary	49	7	74
Post primary	42	10	186

Chi-square = 17.99
d.f. = 2
$p < .0005$
Highly significant

(* Ignoring 5 respondents whose level was not clearly specified)

Table 92/

Table 92

Educational level in relation to reactions to the statement No. 28: "Sexual over-indulgence will end for some people in mental illness" (N = 368)

Statement 28

	Agree	No opinion	Disagree
Primary	58	53	19
Post primary	85	87	66

Chi-square = 7.49
d.f. = 2
.01 < p < .05
Significant

Table 93/

Table 93

Educational level in relation to reactions to the statement No. 32: "Few people who enter a mental hospital ever leave it" (N = 368)

Statement 32

	Agree	No opinion	Disagree
Primary	22	23	85
Post primary	26	29	183

Chi-square = 5.65
d.f. = 2
$.05 < p < .10$
Not significant

Table 94

Educational level in relation to reactions to the statement No. 9: "Most patients in mental hospitals still have to be kept there against their will" (N = 368)

Statement 9

	Agree	No opinion	Disagree
Primary	50	24	56
Post primary	79	41	118

Chi-square = 1.16
d.f. = 2
$.50 < p < .60$
Not significant

Table 95/

Table 95

Educational level in relation to reactions to the statement No. 41: "The mentally ill are unreliable, you never know what they will do next" (N =368)

Statement 41

	Agree	No opinion	Disagree
Primary	82	23	25
Post primary	128	52	58

Chi-square = 2.41
d.f. = 2
p = .30
Not significant

Table 96

Endorsement of self-reliance (Statement 47) in relation to reactions to the statement No. 27: "One of the main causes of mental illness is lack of moral strength" (N =373)

Statement 27

		Agree	No opinion	Disagree
Self-reliance (47)	Agree	102	47	72
	No opinion	12	12	7
	Disagree	42	20	59

Chi-Square = 13.58
d.f. = 4
.005 <p <.01
Significant

Table 97/

Table 97

Religious demonination in relation to reactions to the statement No. 27: "One of the main causes of mental illness is lack of moral strength"
(N = 370)*

Statement 27

		Agree	No opinion	Disagree
Religious denom-ination	Protestant	28	38	75
	Catholic	14	12	16
	Neither	60	26	47

Chi-aquare = 1.97
d.f. = 4
.70 < p < .80
Not significant

(* Ignoring 3 people who did not reply to question on religion)

Table 98

Statement 32. "Few people who enter a mental hospital ever lea ve it", in relation to reactions to the statement, No. 9, "Most people in mental hospitals still have to be kept there against their will"
(N = 373)

Statement 32

		Agree	No opinion	Disagree
Statement 9	Agree	26	5	17
	No opinion	15	20	19
	Disa gree	90	42	139

Chi-square = 23.49
d.f. = 4
p < .001
Highly significant

Table 99/

SECTION 7

Table 99

Sympathy Scale, raw scores

No. of persons	Score	
1	19	a
6	20	
8	21	
16	22	
20	23	
26	24	
29	25	b
37	26	
25	27	
49	28	
31	29	
26	30	
33	31	
25	32	c
13	33	
14	34	
7	35	
3	36	
1	37	
1	38	
1	40	

Table 100/

Table 100

Sympathy Scale, compressed scores

No of persons	Score
7	19-20
24	21-22
46	23-24
66	25-26
74	27-28
57	29-30
58	31-32
27	33-34
10	35-36
2	37-38
1	39-40

Table 101

Sympathy Scale Sections

Section	Score values	No. of respondents
a (unsympathetic)	19-24	77
b (intermediate)	25-31	230
c (sympathetic)	32-40	65

Table 102/

Table 102

Sympathy for the mentally ill in relation to respondents' ranking of "insanity" relative to "mental illness", "nervous breakdown" and "Cancer"
(N = 367)

	Sympathy Scale		
	a	b	c
Insanity ranked 1st	18	78	25
Insanity ranked 2nd	22	83	23
Insanity ranked 3rd	24	45	11
Insanity ranked 4th	11	21	6

Chi-square = 7.848
d.f. = 6
$.20 < p < .30$
Not significant

Table 103

Sympathy for the mentally ill in relation to personal experience of the mentally ill
(N =370)

	Sympathy Scale		
	a	b	c
Experience	39	121	45
No experience	38	107	20

Chi-square = 5.42
d.f. = 2
$.05 < p < .10$
Not significant

Table 104/

Table 104

Sympathy for the mentally ill in relation to visits to mental hospitals. (N =369)

	Sympathy Scale		
	a	b	c
Visited	30	92	29
Never visited	45	138	35

Chi-square = .394
d.f. = 2
$.80 < p < .90$
Not significant

Table 105

Sympathy for the mentally ill in relation to recent information on the subject of mental illness. (N =372)

	Sympathy Scale		
	a	b	c
Information on mass media	22	137	32
Information in conversation	14	13	2
No information	41	80	31

Chi-square = 27.106
d.f. = 4
$p < .0005$
Highly significant

Table 106/

Table 106

Sympathy for the mentally ill in relation to educational level. (N = 370)

		Sympathy Scale		
		a	b	c
Education	Primary	38	75	16
	Post primary	39	153	49

Chi-square = 9.37
d.f. = 2
$.005 < p < .01$
Significant

Table 107

Sympathy for the mentally ill in relation to agreement with the statement: "I think that in general people should be expected to handle their own problems" (self-reliance measure) (N = 372)

		Sympathy Scale		
		a	b	c
Self-reliance	Agree	56	138	27
	No opinion	7	20	3
	Disagree	14	72	35

Chi-square = 18.88
d.f. = 4
$.0005 < p < .001$
Significant

Table 108/

Table 108

Sympathy for the mentally ill in relation to religious denomination. (N =369)

		Sympathy Scale a	b	c
Religious denomination	Protestant	40	122	32
	Catholic	9	24	9
	None	27	82	24

Chi-square = .359
d.f. = 4
.975 < p < .99
Not significant

Table 109

Sympathy for the mentally ill in relation to religious observance. (N = 369)

		Sympathy Scale a	b	c
Religious observance	Attenders	49	146	41
	Non-attenders	27	82	24

Chi-square = .003
d.f. = 2
P < .995
Not significant

Table 110/

Table 110

Sympathy for the mentally ill in relation to sex of respondent. (N = 372)

	Sympathy Scale		
	a	b	c
Male	44	97	25
Female	33	133	40

Chi-square = 5.619
d.f. = 2
$.05 < p < .10$
Not significant

Table 111

Sympathy for the mentally ill in relation to age of respondent. (N = 372)

		Sympathy Scale		
		a	b	c
Age	21 - 29	7	36	13
	30 - 49	20	102	32
	50+	50	92	20

Chi-square = 17.82
d.f. = 4
$.001 < p < .005$
Significant

Table 112/

Table 112

Sympathy for the mentally ill in relation to age of respondent. (N = 372)

		Sympathy Scale		
		a	b	c
Age	21 - 34	11	60	20
	35 - 49	16	78	25
	50+	50	92	20

Chi-square = 17.756
d.f. = 4
$.001 < p < .005$
Significant

Table 113

Sympathy for the mentally ill in relation to age of respondent. (N =372)

		Sympathy Scale		
		a	b	c
Age	21 - 49	27	138	45
	50+	50	92	20

Chi-square = 19.82
d.f. = 2
$P < .001$

Table 114/

Table 114

Sympathy for the mentally ill in relation to male respondents' social class. (N = 162)

	Sympathy Scale		
	a	b	c
Classes I and II	2	14	6
Class III	23	52	14
Classes IV and V	16	31	4

Chi-square = 5.015
d.f. = 4
.20 < p < .30
Not significant

Table 115

Sympathy for the mentally ill in relation to neuroticism score on short form of M.P.I. (N = 371)

		Sympathy Scale		
		a	b	c
Neuroticism Score	0	13	29	12
	1 - 6	34	116	31
	7 - 12	29	85	22

Chi-square = 1.465
d.f. = 4
.80 < p < .90
Not significant

Table 116/

Table 116

Sympathy for the mentally ill in relation to extraversion score on short form of M.P.I.
(N = 371)

		Sympathy Scale		
		a	b	c
Extra-version Score	0 - 4	18	66	13
	5 - 8	29	99	28
	9 - 12	29	65	24

Chi-square = 3.477
d.f. = 4
$.40 < p < .50$
Not significant

Table 117

Sympathy for the mentally ill in relation to presence of child under 15 in respondent's household.
(N = 370)

	Sympathy Scale		
	a	b	c
Child present	28	114	30
Not present	48	115	35

Chi-square = 3.34
d.f. = 2
$.10 < p < .20$
Not significant

Table 118/

Table 118

Interviewer Variation

Respondents' sympathy for the mentally ill in relation to each interviewer

		Sympathy Scale Scores				
		19-22	23-26	27-30	31-34	35-40
Interviewer No.	1	5	24	28	19	6
	2	5	17	10	8	2
	3	5	15	26	18	4
	4	2	2	1	3	0
	5	6	23	31	20	2
	6	2	7	11	10	0
	7	5	19	17	7	0
	8	1	5	7	0	0

Since interviewer No. 4 had only completed eight interviews, and interviewer No. 8 had only completed thirteen, they were discounted and the comparison made, in the next table, No. 119, between the number of respondents interviewed by the remaining six in respect of their levels of scores on the sympathy scale. The scores were re-grouped into three sets for this table.

Table 119/

Table 119

Interviewer Variation

Respondents' sympathy for the mentally ill in relation to six interviewers

Interviewer No.	Sympathy Scale Scores 19-26	27-30	31-40
1	29	28	25
2	22	10	10
3	20	26	22
5	29	31	22
6	9	11	10
7	24	17	7

Chi-square = 9.87
d.f. = 10
$.40 < p < .50$
Not significant

Table 120

Social Distance Scale, compressed scores

No. of Persons	Range of Scores
4	14-20
8	21-24
23	25-28
28	29-32
49	33-36
57	37-40
66	41-44
56	45-48
39/	

Table 120 (continued)

No. of Persons	Range of Scores
39	49-52
32	53-56
6	57-60
2	61-64
1	65-70

Table 121

Social Distance Scale Sections

Section	Score values	No. of respondents
a. (intolerant)	14-32	63
b. (intermediate)	33-49	240
c. (tolerant)	50-65	68

Table 122

Social distance scale score in relation to respondents' ra nking of "insanity" relative to "mental illness", "nervous breakdown" and "cancer" (N = 366)

		Social Distance Scale		
		a	b	c
Rank of Insanity	1	16	78	27
	2	21	83	24
	3	16	53	10
	4	8	23	7

Chi-square = 3.32
d.f. = 6
$.70 < p < .80$
Not significant

Table 123/

Table 123

Social distance scale scores in relation to personal experience of the mentally ill (N = 369)

	Social Distance Scale		
	a	b	c
Experience	31	130	44
No experience	31	109	24

Chi-square = 2.604
d.f. = 2
.20< p<.30
Not significant

Table 124

Social distance scale score in relation to visits to mental hospitals. (N = 368)

	Social Distance Scale		
	a	b	c
Visited	26	96	29
Never visited	36	142	39

Chi-square = .045
d.f. = 2
.975 <p <.990
Not significant

Table 125/

Table 125

Social distance scale score in relation to recent information regarding mental illness. (N = 371)

		Social Distance Scale		
		a	b	c
Information	On mass media	29	124	38
	In conversation	8	16	5
	None	26	100	25

Chi-square = 2.27
d.f. = 4
$.60 < p < .70$
Not significant

Table126

Social distance scale score in relation to educational level. (N = 371)

		Social Distance Scale		
		a	b	c
Educational level	Primary	36	77	15
	Secondary and beyond	27	163	53

Chi-square = 17.95
d.f. = 2
$P < .0005$
Highly significant

Table 127/

Table 127

Social distance scale score in relation to agreement with the statement: "I think that in general people should be expected to handle their own problems" (Measure of self-reliance) (N = 371)

		Social Distance Scale		
		a	b	c
Self-reliance	Agree	45	144	32
	No opinion	3	21	5
	Disagree	15	75	31

Chi-square = 9.633
d.f. = 4
$.01 < p < .05$
Significant

Table128

Social distance scale score in relation to religious denomination. (N = 369)

		Social Distance Scale		
		a	b	c
Religious denomination	Protestant	33	133	28
	Catholic	6	25	11
	None	24	80	29

Chi-square = 4.052
d.f. = 4
$p = .40$
Not significant

Table 129/

Table 129

Social distance scale score in relation to religious observance. (N = 369)

	Social Distance Scale		
	a	b	c
Church attenders	39	158	39
Non-attenders	24	80	29

Chi-square = 1.568
d.f. = 2
$.40 < p < .50$
Not significant

Table 130

Social distance scale score in relation to sex of respondent. (N = 371)

	Social Distance Scale		
	a	b	c
Male	29	106	30
Female	34	134	38

Chi-square = .02
d.f. = 2
$.99 < p < .995$
Not significant

Table 131/

Table 131

Social distance scale score in relation to age of respondent. (N = 371)

		Social Distance Scale		
		a	b	c
Age	21 - 49	20	135	55
	50+	43	105	13

Chi-square = 32.175
d.f. = 2
$P < .005$
Significant

Table 132

Social distance scale score in relation to male respondents' social class. (N = 162)

		Social Distance Scale		
		a	b	c
Social Class	I, II and III	15	70	26
	IV and V	12	36	3

Chi-square = 6.81
d.f. = 2
$.025 < p < .05$
Significant

Table 133/

Table 133

Social distance scale score in relation to the social class of women with an occupation of their own. (N = 98)

		Social Distance Scale		
		a	b	c
Social Class	I, II and III	5	29	6
	IV and V	12	39	7

Chi-square = .5498
d.f. = 2
$.70 < p < .80$
Not significant

Table 134

Social distance scale score in relation to married womens' social class estimated on their husbands' occupation. (N = 172)

		Social Distance Scale		
		a	b	c
	I and II	4	17	3
Social Class	III	18	58	17
	IV and V	9	35	11

Chi-square =0.359
d.f. = 4
$.975 < p < .990$
Not significant

Table 135/

Table 135

Social distance scale score in relation to neuroticism score. (N = 371)

		Social Distance Scale		
		a	b	c
N Score	0 - 6	39	161	25
	7 - 12	24	79	43

Chi-square = 19.17
d.f. = 2
$p < .0005$
Highly significant

Table 136

Social distance scale score in relation to extraversion score. (N = 371)

		Social Distance Scale		
		a	b	c
E Score	0 - 4	19	61	17
	5 - 8	24	104	28
	9 - 12	20	75	23

Chi-square = .5449
d.f. = 4
$.95 < p < .975$
Not significant

Table 137/

Table 137

Social distance score in relation to Sympathy score. (N = 371)

		Sympathy Scale	
		Up to Score 28	Score 29 and beyond
Social Distance Scale	Up to score 44	153	82
	45+	63	73

Chi-square = 12.49
d.f. = 1
$P < .001$